THE ROLE OF THE PROFESSIONAL NURSE IN PROVIDING CONTINUITY OF CARE FOR GERIATRIC PATIENTS AT GROOTE SCHUUR HOSPITAL

- by -

JUDY DICK

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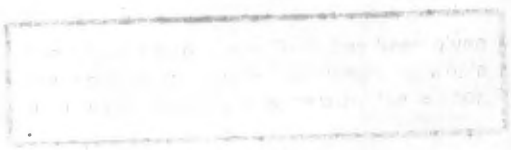

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ABSTRACT

Due to the fragmented structure of the health organisation in South Africa, there is often difficulty in assuring good co-ordination between in-patient and domiciliary health facilities. This results in the discharge of patients from hospital with poor prospects for the continuity of health care in the community. At Groote Schuur Hospital, approximately 44% of the hospital beds in the white section of the Hospital are occupied by patients in the age group of sixty-five years and over. This group of patients must be regarded as particularly vulnerable with regard to the transition of the care in a hospital to their own home for some of the following reasons:-

* The nature of the disease - The chronic and recurrent nature of the degenerative diseases of old age often results in varying degrees of disability in the aged patient. Many geriatric patients suffer from several unrelated clinical conditions, and thus there is a need to co-ordinate the many health services required.

* Social circumstances - The aged population frequently live alone or with a frail relative, often in poor economic circumstances.

* Re-admission rate - The geriatric re-admission rate following discharge is high.

As the first principle of geriatric care is to restore independence, and to help patients live away from the hospital environment, the provision of extended care facilities for vulnerable patients is of utmost importance.

A structured interview was used to assess the need for extended care facilities of 172 white patients over the age of 60 years who were discharged from Groote Schuur Hospital during March to May of 1981. An attempt was made to evaluate how effectively these needs were being met in the community following discharge. It was found that 34% of the patients interviewed were not getting the nursing care and support in the community which they needed to facilitate rehabilitation. The most vulnerable patients as regards aftercare were:-

* The aged
* The chronically ill
* Patients who live alone or without social support
* Patients whose illness leads to temporary or permanent disability
* Patients hospitalised for prolonged periods

It was found that the patients interviewed were given insufficient preparation, while still in hospital, for the problems they would be faced with on discharge. No systematic policy exists to ensure that health care staff give adequate information to the patient on discharge from hospital.

The ward sister was found to play a vital role in making the preparations for a patient's transfer from hospital to home. A questionnaire was designed to assess the Groote Schuur ward sisters' attitudes towards the importance of discharge planning. An analysis of the ward sisters' response indicated that great variation existed in the attitudes towards the importance of this task.

An investigation into the existing community services for geriatric patients was undertaken. An attempt was made to assess the limitations and gaps which exist in the provision of services for the aged.

Finally, the role of the recently established Department of Community Liaison at Groote Schuur Hospital was investigated. It was evident that the Community Liaison nurse had proved to be an invaluable member of the health team of a large, specialist hospital such as Groote Schuur. The activities of the Community Liaison nurse led to improved continuity of care for patients needing extended care facilities in the community.

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PART ONE

CHAPTER 1

THE ROLE OF THE NURSE IN THE HEALTH TEAM

"Our problem is not to find better values but to be faithful to those we profess - to make them live in our institutions".

John W Gardner

Health care is a multidisciplinary activity given by members of the health team with the aim of improving the health of the individual. Health has been defined by the World Health Organisation as "not merely the absence of disease, but the achievement of an optimum level of physical, mental and social well-being".

Nurses, as members of the health team, make a unique contribution to patient care. Clarification of this contribution leads to greater understanding between the different members of the health team. Effective communication is directly related to improved quality of health care. Societal health needs are changing, and consequently the nurse's role is evolving in order to fulfill these needs. An advance in medical science and technology has led to increasing specialisation in nursing. Increasing emphasis on community health has led to the nurse assuming greater responsibility in the prevention of disease and the promotion of health.

The doctor and the nurse are the two members of the health team with overall generalist function - in that they are not specialised to perform a particular isolated function, as are team members such as physiotherapists, occupational therapists, dieticians, etc. The nurse's relationship

with the doctor has been regarded as a complementary one. An effective way of describing this complementary function is on a 'CURE-CARE' continuum.

The doctor's role revolves around the cure component. His function begins with a diagnosis which is based on an analysis of the patient's symptoms and the clinical investigations which have been conducted. Once the diagnosis has been made, treatment by a variety of modalities is attempted in order to achieve a cure. When the condition is unable to be cured, the goal becomes the remission of symptoms and the alleviation of distress. This philosophical framework is referred to in sociological terms as the "Medical Model". In the medical model all resources are directed towards the procuring of more effective diagnostic machinery, a search for better diagnostic methods and methods of treatments and research into the nature of the disease, its diagnosis, treatment and the differential cure rates for the different modalities of treatment. (14)

The philosophical framework of nursing is balanced more towards the care component of the 'CURE-CARE CONTINUUM'. It is the nurse's responsibility to provide the essential continuous physiological and psychological care of the patient. Her function begins with the assessment of the limitations which the disease has caused the patient in his daily living activities. Virginia Henderson aptly described the unique function of the nurse as

> "to assist the individual, sick or well, in the performance of those activities contributing to health, or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible". (7)

Thus the nature of nursing is assisting the patient in his daily living activities to retain or resume an optimum level of well-being. Therefore, along with the prime medical function of the diagnosis, treatment and cure of disease, there is the equally important nursing function of assessing the patient's disfunction in daily living activities, and assisting him to overcome these problems. This is what is meant by nursing care. (12)

The functions of the doctor and the nurse are not autonomous. Doctors frequently provide care to the patient, whilst nurses are involved in assisting with cure regimes. When the nurse is involved in the nursing model, she works independently. However, if the nurse becomes involved in the medical model, her function is dependent upon the doctor. By law, he is the only member of the health team authorised to diagnose and prescribe medication. She is legally responsible and accountable for all her nursing care functions. (14) (4) Nursing as a profession began to develop during the nineteenth century, at the time of great social reform, and the advancement of medicine as a science. At this time, the nurse was regarded as the physician's helper. Her function was entirely dependent upon his instructions. Nursing care consisted of rather stereotyped activities which were almost ritually performed by the nurse following the pronouncement of the medical diagnosis. From this task-orientated basis, modern nursing has evolved into a more individual-orientated process. The modern professional nurse assesses the patient's health needs, plans, and implements an individualised nursing care plan to fulfill these needs, and then evaluates the effectiveness of the nursing action.

The increase in modern medical technology has necessitated nurses to gain in-depth knowledge in specialised areas of

patient care, e.g. coronary care, renal transplant units, etc. On the other hand, there is a deliberate reaching out by nurses for new and less traditional functions. During the last few years nurses have begun to perform tasks that are traditionally and officially considered the prerogative of the doctor. As the professional nurse assumes more and more responsibility for cure functions in patient care, there is a tendency for her to abandon some of her traditional tasks in patient care to less trained personnel such as nursing assistants. Thus, though medical care will improve as a result, nursing care will deteriorate.

It has often been argued that nursing is not, and probably never can become, a fully fledged profession. (5) (9) The main reasons for this are that it cannot develop its own specific body of unique knowledge, and secondly, that nurses can never act in a fully autonomous way given their dependence on medical authority. If nursing increasingly confines itself to the medical model with its overriding concern with cure, these points will probably be valid. If, however, nursing places greater emphasis on its primary function of care, a basis for the development of an autonomous body of nursing knowledge and independent responsibility will occur.

Advances in medical science have caused societal health needs to change. As people are increasingly living out their potential lifespan, the proportion of aged in the population is increasing. People with chronic and disabling diseases are living longer. As Illich reminds us,

"We must not mistake medical care for health care". (3)

The medical model, with its dominant focus on the prevention, diagnosis and treatment of disease, is ill-suited to the degenerative problems of an ageing population and health behavioural problems such as obesity and alcoholism. When what is curable has been cured and what is preventable has been prevented, there is still a great deal left. "And what it needs is care". (4)

Health is a multidisciplinary activity given by the health team to which nurses make a unique contribution. The contribution of nursing is primarily helping and assisting the patient perform the activities which he normally would be able to do for himself. Nursing action is modified by the therapeutic plan carried out by the doctor. Because she works with members of a multidisciplinary team, there is a co-ordinating role in nursing care. Nursing is predominantly an interactive process with the patient, and thus she has a communicating and counselling function. Helping, caring, communicating, counselling and co-ordinating - these are some elements of nursing care. (13) Continuity and comprehensiveness are the essential ingredients of quality nursing. In an increasingly complex health care system, the need for the nurse who will support the patient and his family through crises, co-ordinate the multiplicity of services, and mobilise necessary health resources, is becoming increasingly important.

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PART ONE

CHAPTER 2

BACKGROUND TO THE SURVEY

Medical and social progress has brought about a lengthening of the human lifespan. The number of elderly is increasing both in absolute numbers, and in proportion to younger members of the population. The rate of increase of the aged is more marked in developed communities. Statisticians expect that by the year 1987, 20% of the population of the United Kingdom will be over the age of 65 years. At present in the Republic of South Africa, approximately 8% of the developed section, and 3% of the developing section of the community are over 65 years of age. (26) Ageing is a natural phase of life, but as the years increase, health and vitality generally decrease and the old person becomes more dependent upon others for his care. (16)

Implications of an ageing population for the Health Service

The increasing number of aged in the community has formidable implications for the health service. The age group of 75 years and over is estimated to absorb five times as many health and welfare services as the 65-75 year age group. 25% of all patients admitted to hospital may be classified as geriatric. (30) Not only are the aged admitted to hospital more frequently than younger age groups, but they are estimated to remain in hospital for twice as long as their younger counterparts. (37) These figures reveal the extensive needs of the older population groups for medical and social services.

The increase in the prevalence of chronic illness

It is logical that with an increase in life expectancy, there will be a corresponding increase in the percentage of the population who are at risk from debilitating and protracted degenerative diseases. As the incidence of acute illness and infections is reduced by preventive medical measures and chemotherapy, so chronic illness becomes more widespread. The predominance of acute illnesses with their rapid and easily recognisable onsets has given way to a pattern of illnesses characterised by their episodic nature and insidious onset. This change from the predominance of acute illness to chronic illness, has resulted in a change in the pattern of health care delivery. Hospital Departments, both inpatient and outpatient, tend to see more patients many times, for short periods, rather than a small number of patients of fewer occasions for longer periods, as is the pattern when dealing with acute illness. (11)

The incidence of chronic illness increases with advancing age. Multiple pathology is a recognisable feature of chronic illness, and thus of geriatric medicine.(6,15,34,36) Although the definition of chronic illness has frequently been associated with certain diseases which tend to run a protracted course, e.g. cardiovascular disease, diabetes or malignancy, it is perhaps better identified with medical conditions which result in a reduction of functional ability. The aged must be regarded as a vulnerable group as they are particularly susceptible to physical and mental deterioration at times of crisis.

The objectives of Geriatric Care

Geriatric medicine may be defined as that branch of general medicine concerned with the clinical, social, preventive and remedial aspects of illness in the elderly. (2) The main aim of the care of the aged is to keep the patient living as independent and useful a life in the community for as long as possible. As the incidence of disability increases with age, the rehabilitative process is a vital element in the geriatric approach. It is essential that the highest possible functional competence and psychological integrity be restored.

The Growing Concern for the aged Patient discharged from Hospital

Due to the fragmented structure of the health organisation in South Africa, there is often difficulty in assuring co-ordination between the inpatient facilities, and those facilities which exist in the community. This may result in the discharge of patients from hospital with poor prospects for follow-up care in the community.

The aged group must be regarded as particularly vulnerable with regard to the transition of care in the hospital to their own homes. Why?

1. The Nature of Morbidity

There are three factors correlated with the diseases which affect the aged. Firstly, this age group tend to be affected by chronic disease. Secondly, the pathologies tend to be multiple, and thirdly, they lead to increasing disability.

In a survey which Dr Beyers did at the Geriatric Clinic at Tygerberg Hospital in 1979, he revealed the following morbidity figures when dealing with the aged: 71% had arthritic conditions, 54% cardiovascular disease, 35% essential hypertension, 31% urinary conditions, 29% respiratory tract disturbances, 26% gastro-intestinal lesions, 20% neurological lesions, 12.5% malignant tumours, and 10% either diabetes mellitus or anaemia. Obesity was a complicating factor in 35% of the patients studied. (3) The main causes of death in these patients were ischaemic heart disease, cerebrovascular accidents, cancer and respiratory disease.

In a community survey of the white aged in Cape Town, conducted by Gillis and Elk during 1978, the authors stated that 33% of their sample were incapacitated due to physical illness and impairment of function. Incapacity was only associated with significant degrees of impairment in the ability to cope with the normal demands of daily living. Reasons for incapacity were: pain 18.4%, mobility problems 12.5%, visual defects 10.5%, dyspnoea 10.5%, defective hearing 8.5%, and other reasons such as epilepsy, Parkinson's disease, etc., 4%. (15) This disability makes the older person dependent on others for his care.

In the extensive research project conducted to investigate the prevalance and epidemiology of chronic illness in non-institutionalised persons living in Cape Town, Dick et al stated that 29.9% of the Coloured population and 21% of the white population over the age of 65 years were chronically ill. (6)

The chronic and recurrent nature of the degenerative diseases of old age often results in varying degrees of disability. As so many geriatric patients suffer from several unrelated clinical conditions, there is a need to co-ordinate the many health services required.

2. Social Circumstances

What are the living conditions of the aged?

Mrs Droskie, the Director of the South African National Council of the Aged, revealed that approximately 70% of the elderly live independently in the community, either alone or with an aged spouse. 25% live with their children or friends, whilst only 5% are resident in old age homes. (8)

Gillis and Elk revealed that 60% of their sample of aged white people in Cape Town in 1978, had an annual income of less than R3 000. Despite this, only 12% complained of poverty. As the cost of living has risen considerably since this survey, the financial position of pensioners may have changed. (15) The State pension for whites, Coloureds and Blacks is R122, R71, and R40 per month, respectively.

Of the group studied by Gillis and Elk, two thirds of their sample were female, and one third male. This corresponds with other demographic figures obtained of age group 65 years and over. 40% of their sample were still married, and 30% were over the age of 75 years. The general assumption that elderly people tend to be socially isolated was not substantiated. The majority of their sample had frequent contact with friends and relatives, and could be considered well supported. 19% had poor social contacts, and 10% could be considered as completely lacking social and

and emotional support. Of the 91% of their sample who were retired, 11% had difficulties related to the lack of occupation and purpose of life. (15)

Thus it must be deduced that geriatric patients' living conditions make them a vulnerable group as they frequently live alone or with a frail relative, their mobility is reduced, and they have limited financial resources.

3. The Re-admission Rate of Geriatric Patients

The re-admission rate of the elderly following discharge is high. Research studies looking at bed occupancy found that geriatric patients were kept longer in acute beds because they needed help during the period of rehabilitation with activities such as dressing and feeding.

In a study done by Hofmeyr and de V. Meiring in 1975, they estimated that approximately 26% of geriatric patients constituted a problem regarding discharge. (23) A high percentage of these patients suffered cerebrovascular accidents, were in their late seventies, and often had no close relatives. Their functional state was poor and they were thus house-bound and dependent. A high percentage of this group were mentally confused. These medical and social factors played a very real part in rendering a patient undischargeable. (23)

This then becomes and economic problem. Groote Schuur, as both an acute hospital and a teaching

institution, in an expensive complex to run; e.g. in 1980, the mean cost per bed per day at the following hospitals were as follows:-

Groote Schuur Hospital (Acute Hospital) - R77,72
Conradie Hospital (Chronic care Hospital) - R28,08
Eaton Convalescence Home (Convalescent Hospital) - R16,78

Thus, in an acute hospital such as Groote Schuur, every attempt should be made to decrease the length of stay in hospital to an absolute minimum, and to place geriatric patients who require a long period of rehabilitation in more appropriate and less expensive accommodation as soon as possible.

As the first principle of geriatric care is to restore independence and help the patient live away from the hospital environment, a great deal of emphasis must be placed on planning a rehabilitative programme. The discharge of the patient is merely a critical point along the continuum of rehabilitation.

The Discharge of the Geriatric Patient

It has long been recognised that the period around the discharge of hospital in-patients is an area of concern in the delivery of health care. Illness in the older patient frequently leads to a marked deterioration in functional ability, resulting in difficulties with the activities associated with daily living. The patient moves from the highly supportive hospital environment to his home which might be unsuitable for convalescence.

Nursing staff, due to their close association with patients, are often acutely aware of the anxiety provoked by the news of discharge to a frail and dependent old person. Due to the pressure to vacate the "blocked bed", making alternative arrangements for geriatric patients seems a frantic and frustrating experience. There seems little planning for aftercare and no policy for ensuring continuity of care. The criteria for discharging an elderly patient might not be that the patient's physical condition has improved, but that the hospital medical staff can do nothing further to improve his chronic condition.

Concern about the organisation of aftercare for patients' being discharged, has also been stimulated by the recognition that adverse social circumstances have a detrimental effect on the patient's response to medical treatment. Attempts to understand and rectify any social disadvantages are inseparable from the provision of good health care.

Ferguson highlights the economic aspects of the problem. In his report of a two-year follow-up study of discharged hospital patients, he records a number of cases in which subsequent re-admission was thought to be attributable mainly to environmental conditions or a breakdown in practical social support, rather than purely medical factors. He quotes many incidences when the benefits of earlier treatment had been nullified through a failure of follow-up care. A significant number of the patients in his sample suffered from chronic conditions for which further treatment in hospital was unlikely to offer more than relief of acute symptoms. Their re-admission to hospital blocked an acute bed for a patient who might have derived some permanent benefit from it. The failure to mobilise existing rehabiliative community resources is an expensive omission. (10)

Surveys of recently discharged hospital patients have highlighted some of the inadequencies in the transition from hospital to home. Madsen reported on the attitudes of patients from one hospital, on the preparations that had been made for their discharge. Although the patients generally did not see their aftercare as the responsibility of the hospital staff, the interview data revealed that 40% of the group were dissatisfied with the arrangements surrounding their discharge. 32% had run into unexpected problems, and 26% of the group would have appreciated more information and improved conditions on discharge. (21)

Continuity of care is the central problem of an extensive study undertaken by Hockey. In her research project, "Care in the Balance", Hockey found that almost 20% of the patients interviewed felt in need of some help which was not being supplied. The needs which most patients expressed were categorised as "domestic and/or simple nursing help", or "medical or nursing advice and reassurance". The findings indicated that a relatively high proportion of patients would have benefited from professional advice and reassurance, even when no specific practical service seemed necessary, or could have been provided. (17, p 52) The patients' families carried the burden of simple nursing care, and would have benefited from some professional guidance and support. (17)

Muriel Skeet in her survey, "Home from Hospital", highlighted some of the inadequacies in the transition between hospital and home. She found a serious lack of co-ordination between hospital and community services. Patients were discharged without adequate notice, and the information was given to them or their families regarding the continuation of their treatment. Few were referred to community staff or services. (30)

Roberts, in her research project, "Discharged from Hospital", made an attempt to assess the effectiveness of care patients received following a stay in hospital. One hundred and sixty-four patients were interviewed about their ability to perform a number of daily living activities, such as personal and toilet care, simple domestic tasks and essential shopping. Of the sample, 117 patients reported some incapacity, 96 felt that the compensatory care that they received was unsatisfactory. The majority of this care was provided by their family and friends. (29)

Nurses are mostly concerned with the patients' personal care. The work of Madsen, Hockey, Skeet and Roberts, represents the concern to understand more fully the problems associated with planning good aftercare. It is assumed that it is the responsibility of the hospital staff to make adequate arrangements for continuation of care in the community.

The problem of providing continuity of care is particularly relevant to a hospital like Groote Schuur. Groote Schuur is a closed hospital which does not accept the more privileged private and medical aid patients. Cape Town area has a higher distribution of aged people than other urban areas, i.e. 8.4% of the population is over the age of 65 years, whereas the norm in urban areas is 6.5%. It has been calculated that approximately 44% of the hospital beds on the white side of the hospital are occupied by geriatric patients.

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PART TWO

CHAPTER THREE

THE RESEARCH METHOD

The survey was designed as a descriptive epidemiological study:-

1. To elicit the nursing needs of white patients over the age of 60 years who are discharged from Groote Schuur Hospital.

2. To evaluate how effectively these needs were being met in the community following discharge.

Definition of Criteria

"Nursing Needs"

'Nursing' is

> "the performance of those activities contributing to health, or its recover (or to a peaceful death), that a patient would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible". (1)
>
> (Virginia Henderson)

"Need". The focus of attention in nursing is on the patient's deficit or area of dependence. A need that the patient is unable to satisfy himself, calls for intervention by the nurse, who, concentrating her attention on what is lacking, attempts to assist the patient to regain an equilibrium.

Selection of Patients for the Study

A list was made of patients who had been discharged from Groote Schuur Hospital from 1 March 1981 to 15 May 1981, who adhered to specific criteria. The Admission and Discharge register at the Admission Office at Groote Schuur was used to comply this list.

Criteria for discharged Patients' inclusion in Study:-

1. Patients of 60 years of age, or older, were selected.

2. Patients were racially classified as white.

3. Patients had been treated at Groote Schuur for 48 hours or longer.

4. Only patients who had been discharged to their own homes were included. Patients discharged to custodial care were not included in the survey.

5. The patient's residential address on admission to Groote Schuur Hospital had to be within the Municipality of Cape Town.

Method of Data Collection

A structured interview (Appendix 1) was constructed with the aim of finding out information regarding aspects of:-

* The advice given to the patient and his family by the hospital staff on discharge.
* The patient's attitude to discharge.
* The method by which the patient was transported home.
* The home situation.
* The patient's level of disability on discharge.

* Treatment to be continued on discharge.
* Follow-up and supportive community care following discharge.

The information was collected by personal interview with the patient and his family members. The interviewers were a group of thirteen registered nurses who were completing a Diploma in Community Health at the Cape Technikon. Interviews were conducted in the patients' homes from 19 May until 2 June 1981.

No appointments were made prior to the first call. If the patient was not at home on the first call, two subsequent attempts were made to meet the patient. It was decided that if the third attempt failed to find the patient at home, the patient would not be included in the survey. An attempt was made to find out from neighbours where the patient was, e.g. re-admitted to hospital, change of address, or subsequently deceased.

The duration of the interviews ranged from twenty minutes to one hour. Often the interview was conducted in the presence of a third person, e.g. a family member or domestic helper. This might have influenced some of the answers which were given. It was invaluable to meet the family members as they were often the ones who carried the burden of caring for the patient post-discharge.

A short introduction to the structured interview explained that the survey was being done to find out more about how people manage following discharge from hospital. Participants were reassured that all information about individuals would be treated as confidential. A letter authorising the interviewer's status was shown to the interviewee following their initial introduction.

The difficulty of role differentiation of the interviewer who was acting as an objective data collector on one hand, and yet also filled the role as a source of advice and nursing care on the other, was circumvented by the interviewer delaying any of the patient's personal questions until all data had been collected. At the end of the interview, she was able to give advice and support. This happened frequently when the interviewer was able to solve some of the patient's immediate problems, or refer him to a suitable service in the community.

Non-response

Appointments were not made with patients. If the patient was not available following three well-spread visits, the interview was deemed unobtainable.

A total of 268 patients, adhering to the stated criteria, were obtained from the Admission and Discharge register, as having been discharged during the period 1 March to 15 May 1981. Of the group, 96 patients were not able to be interviewed.

Reasons for Non-response	% of patients
Patient died	9%
Not at home	13%
Re-admitted to hospital	4%
Not capable of being interviewed	0.5% (1 patient)
Refused interview	1.5%
Untraceable	8%
Total	36%

TABLE 1 - REASONS FOR NON-RESPONSE

The one patient who was incapable of being interviewed, was suffering from senile dementia. The reasons for classifying a patient as untraceable were numerous. Some patients had come to the Cape specifically to obtain treatment at the specialist units at Groote Schuur Hospital. They had subsequently returned to their homes in other parts of South Africa or overseas. Some patients had given the hospital the incorrect address, whilst others had moved from their homes into custodial care e.g., old age homes, following a short period of convalescence.

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PART TWO

CHAPTER 4

PRESENTATION OF DATA

This chapter is a description of the information which was obtained from the survey.

1. Characterists of all Patients selected for the Survey

1.1 Sex Distribution

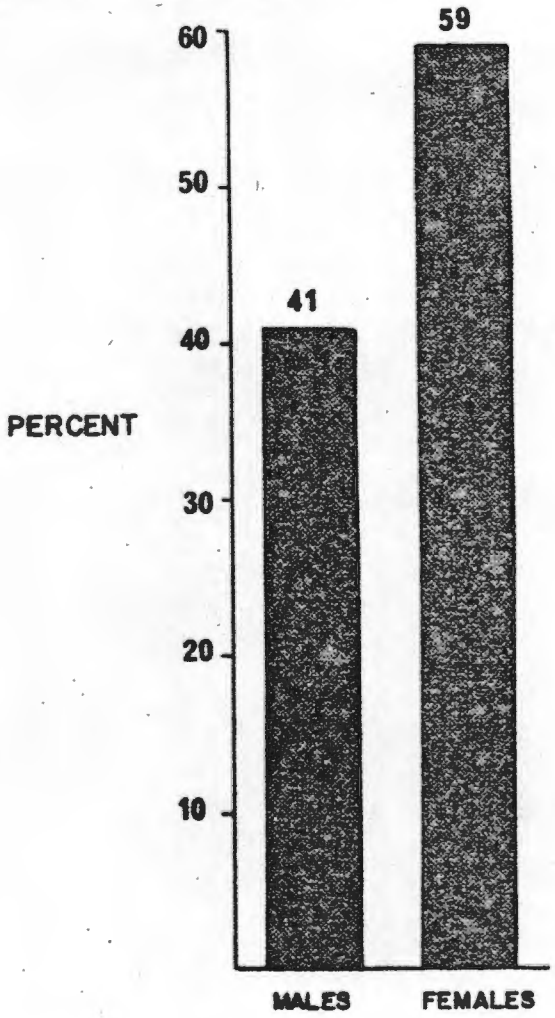


FIGURE 1 - SEX DISTRIBUTION OF PATIENTS SELECTED FOR THE SURVEY

This distribution is more or less consistent with the distribution of the elderly population in other parts of the world. (6)

1.2 Age Distribution

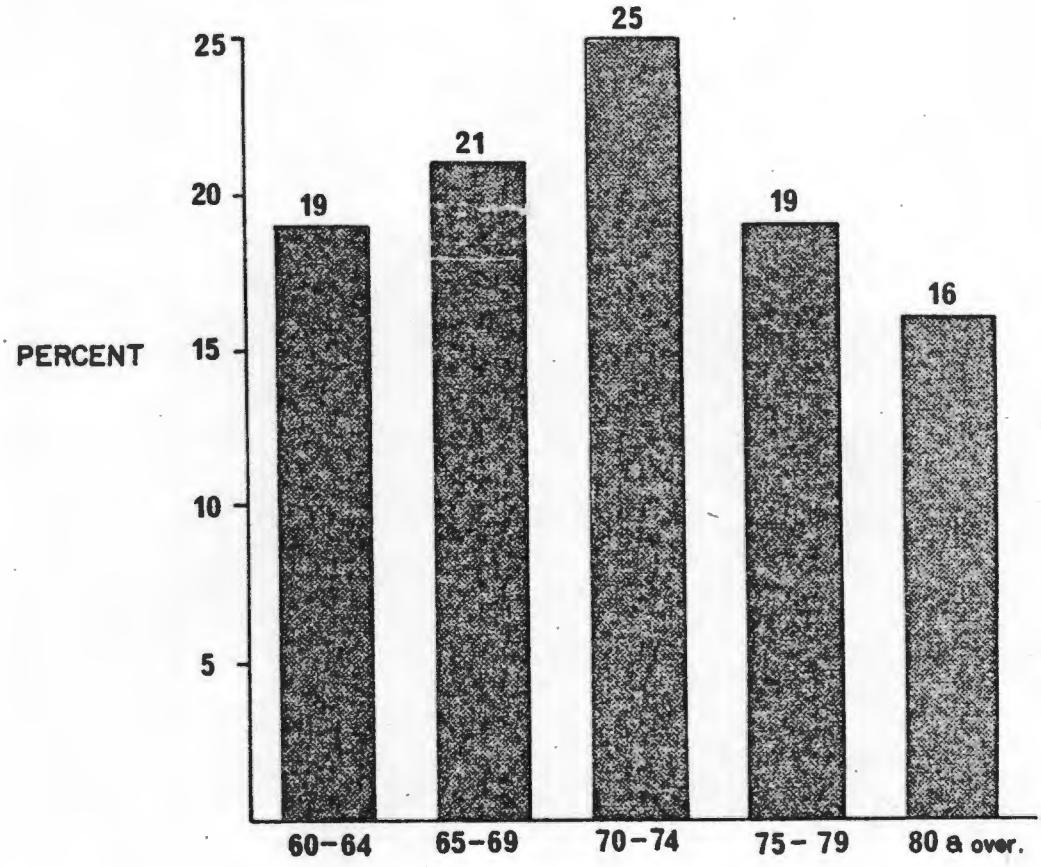


FIGURE 2. AGE DISTRIBUTION OF PATIENTS SELECTED FOR THE SURVEY.

This shows that the study comprised of a relatively elderly population, as 35% were 75 years and over. The proportion of female : male patients increased dramatically in the age groups of 70 and over, i.e. approximately 5 : 3. This adheres to the mean life expectancy of the white population which is 65.5 years in the male, and 72.3 years in the female group. (2)

1.3 Employment Status

Age	Unemployed	Employed
60 - 64	35	15
65 - 69	43	12
70 - 74	62	6
75 - 79	49	2
80 & over	43	1
	232 = 87%	36 = 13%

TABLE 2 - EMPLOYMENT STATUS OF PATIENTS SELECTED FOR THE SURVEY

Eighty-seven percent of the population were retired, whilst 13% were actively employed. Of the employed group, only 9% were working in a part-time capacity. This distribution is similar to the figures obtained by a community survey undertaken in March 1978. (6, p 147)

1.4 Environmental Setting

In order to gain a picture of the distribution of patients' residential setting, the area was broken down into zones.

Zone 1 - Camps Bay, Fresnaye, Seapoint, Green Point, Mouille Point, and Three Anchor Bay.

Zone 2 - City, Tamboerskloof, Oranjezicht, Gardens, Vredehoek.

Zone 3 - University Estate, Woodstock, Observatory.

Zone 4 - Mowbray, Rosebank, Rondebosch, Newlands.

Zone 5 - Claremont, Kenilworth, Wynberg.

Zone 6 - Plumstead, Diep River.

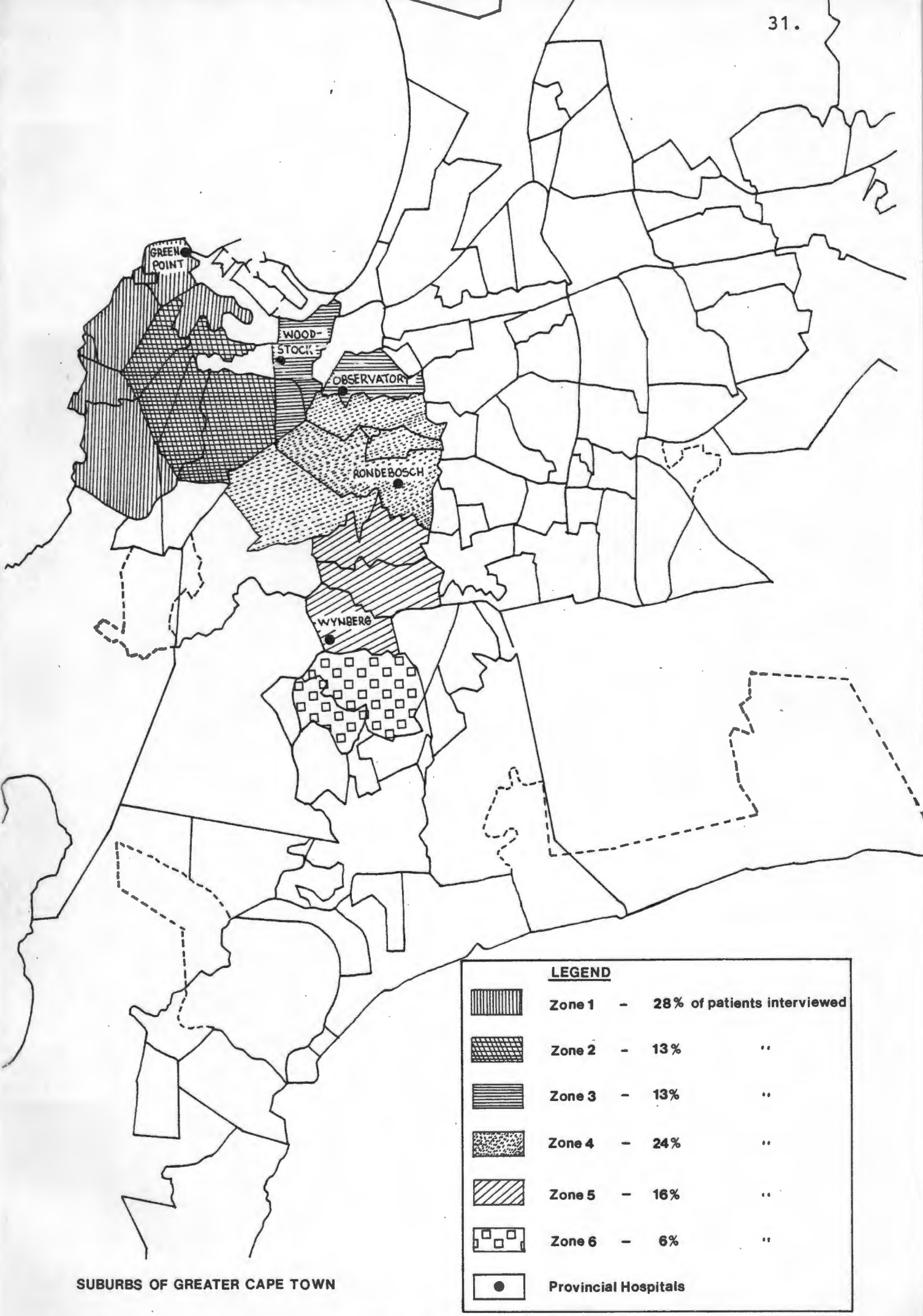
Area of Abode	Distribution of Patients
Zone 1	28%
Zone 2	13%
Zone 3	13%
Zone 4	24%
Zone 5	16%
Zone 6	6%

TABLE 3 - DISTRIBUTION OF PATIENTS' RESIDENTIAL SETTING

1.5 Date of Discharge

The group of patients interviewed were discharged from Groote Schuur Hospital during the period 1 March to 15 May 1981. It was felt that, as the interviews were conducted towards the end of May, and in early June, patients would have a clear memory of hospitalisation and of convalescence.

28% of the group were discharged during the period 1 - 31 March; 45% of the group were discharged during the period 1 - 30 April; 27% of the group were discharged during the period 1 - 15 May. Several of the patients were re-admitted to hospital for further treatment during this period. If this was the case, the patient was asked to discuss only his last discharge experience.



SUBURBS OF GREATER CAPE TOWN

TABLE 3. DISTRIBUTION OF PATIENTS RESIDENTIAL SETTING

1.6 Length of Stay in Hospital

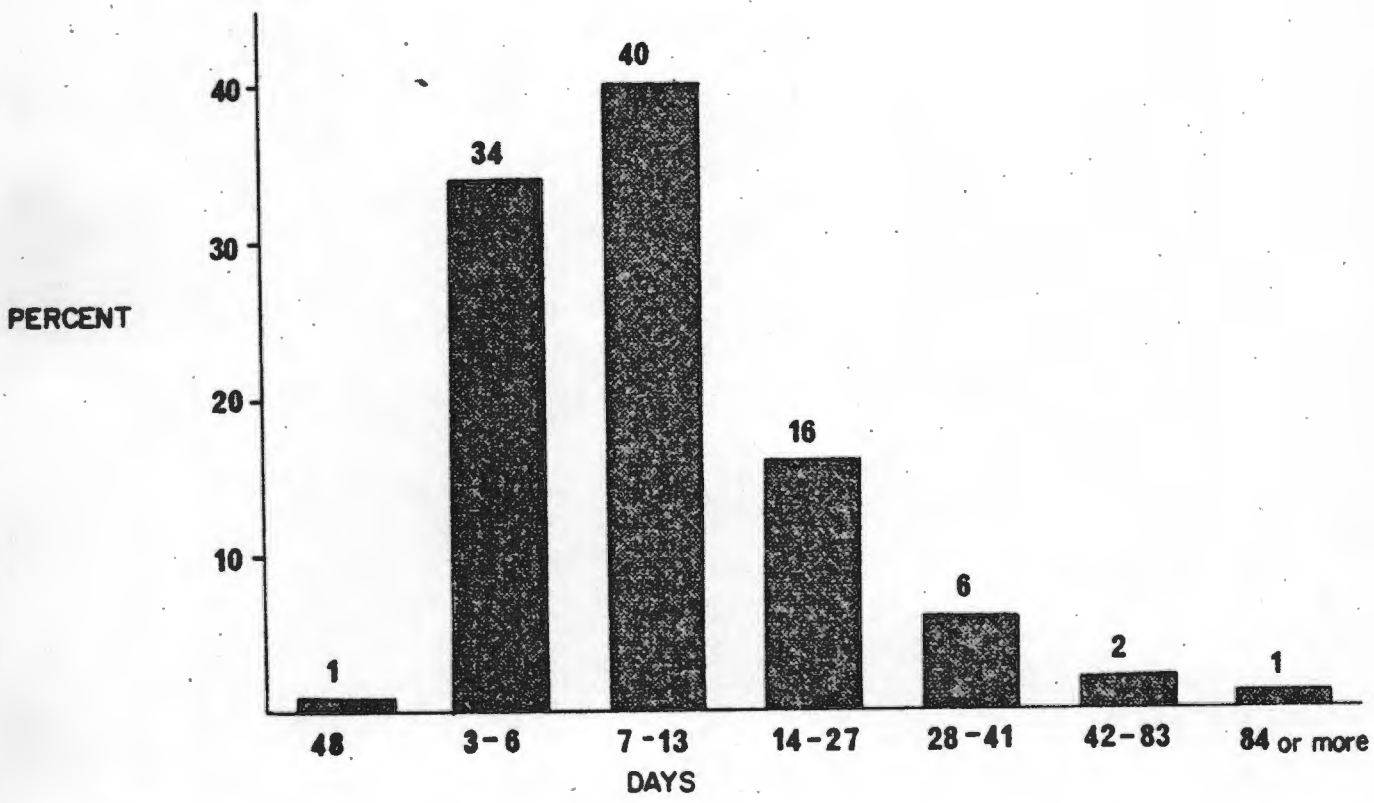


FIGURE 4 LENGTH OF STAY IN HOSPITAL

It was felt that patients who were admitted to Groote Schuur Hospital for a period of less than 48 hours would have had such a transient experience of hospitilisation, that rehabilitation following discharge would present few problems. It was for this reason that only patients who remained at Groote Schuur Hospital for 48 hours or longer, were included in the study.

The duration of stay in hospital is a factor most likely to affect the patient's overall circumstances when discharged home. A long period of of hospitalisation could be expected to have the adverse effect of institutionalising the patient. It also indicates the severity of the patient's illness and subsequent potential problems during

rehabilitation.

The average length of time spent in hospital is 8 days at Groote Schuur Hospital. (1, p 133-134) Twenty-five percent of the patients selected for the survey spent longer than fourteen days in the hospital wards at one time of admission. Considering that Groote Schuur Hospital is a hospital designed for short-term acute care, with no facilities for the long-term care of chronic illness, this indicates that older patients stay longer in hospital. The average stay of patients selected for the survey was 13½ days. It is felt by the staff at Groote Schuur Hospital, that one of the reasons for an older patient's protracted period of hospitalisation, is their lack of support in the community.

2. Characteristics of the patients who were interviewed

2.1 Sex Distribution

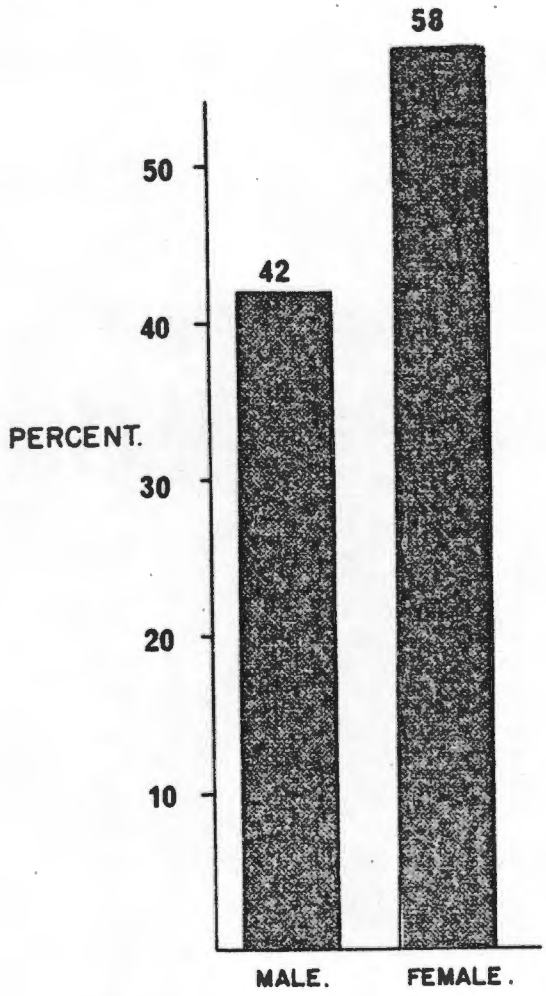


FIGURE 5. SEX DISTRIBUTION OF PATIENTS INTERVIEWED.

This distribution corresponds almost exactly with the ratio of male : female in all the patients selected for the survey.

2.2 Age Distribution

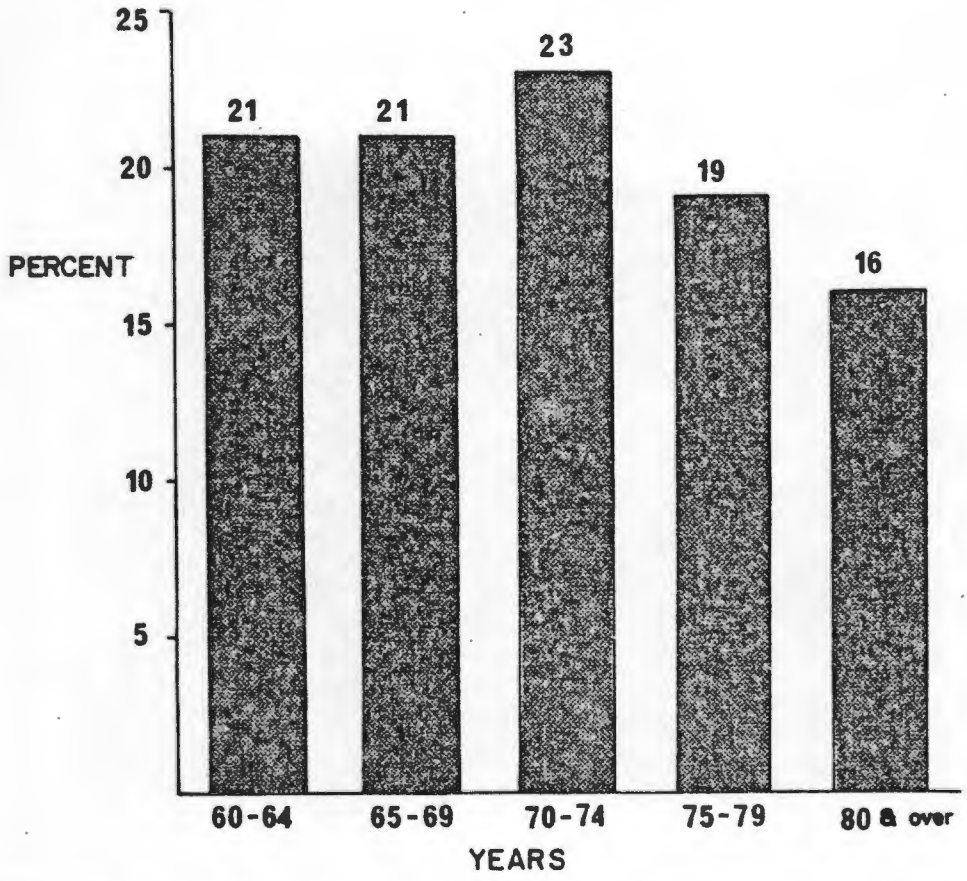


FIGURE 6. AGE DISTRIBUTION OF PATIENTS INTERVIEWED.

2.3 Employment Status

Age	Unemployed	Employed
60 - 64	27	9
65 - 69	31	5
70 - 74	34	6
75 - 79	33	0
80 years & over	27	0
	152 = 88%	20 = 12%

TABLE 4 - EMPLOYMENT STATUS OF PATIENTS INTERVIEWED

2.4 Environment Setting

Area of Abode	Distribution of Patients
Zone 1	22%
Zone 2	14%
Zone 3	14%
Zone 4	26%
Zone 5	16%
Zone 6	8%

TABLE 5 - DISTRIBUTION OF PATIENTS WHO WERE INTERVIEWED - RESIDENTIAL SETTING

It was found that although there was a non-response rate of 36% of patients selected for the survey, the social characteristics of the total population mirrored very accurately those of the group of patients who were interviewed.

3.1 Notification of the date of Discharge

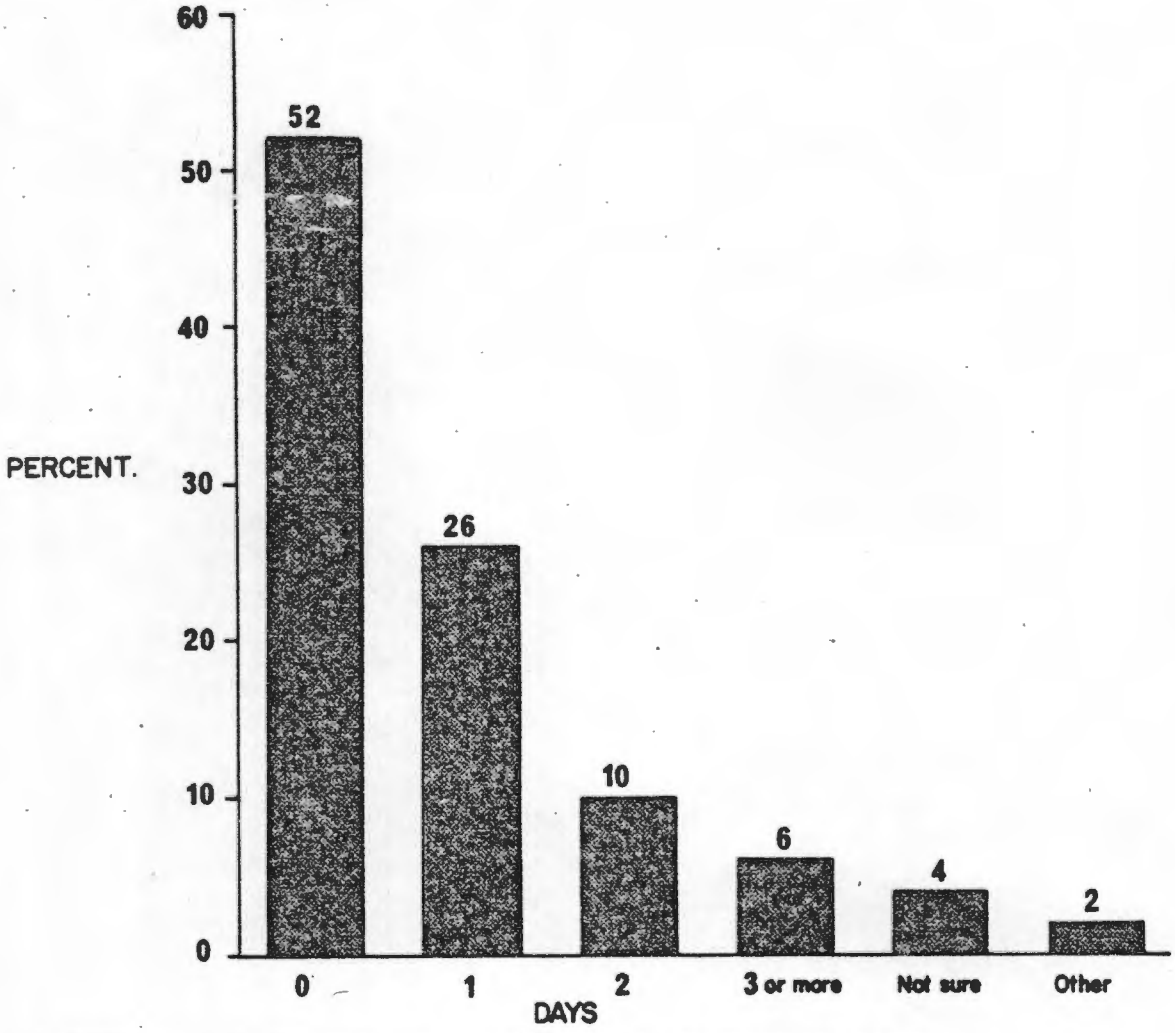


FIGURE 7. ADVANCE NOTIFICATION OF DISCHARGE DATE.

FIGURE 7 - ADVANCE NOTIFICATION OF DISCHARGE DATE

Fifty-two percent of patients were only told on the actual day of discharge that they could go home. This included 58% of the patients who had been hospitalised for longer than fourteen days. Twenty-six percent of the patients were told of their imminent discharge the day before, a further 10% were given two days to plan for their discharge. Only 8% of the patient population were given a long-term prediction of their date of discharge.

As some of the patients were dependent upon relatives coming to stay with them, or taking time off work to care for them when they first came home, it is felt that the patient and his family should have the benefit of early planning regarding the discharge date. Prediction of the discharge date is particularly important for patients who live alone, or who have been hospitalised for a fortnight or longer.

3.2 Who first told you of the date of Discharge?

This question was asked to ascertain the person who assumed responsibility regarding giving information about the predicted discharge.

Doctor	87%
Ward Sister	10%
Student nurse	1%
Other	1%
Not sure	1%

TABLE 6 - PERSON RESPONSIBLE FOR INFORMING PATIENT OF DISCHARGE DATE

The majority of patients were told the date of discharge by their doctor. Surprisingly few, only 10%, were given this information by the ward sister. None of the patients were told the predicted date of discharge by the social worker, although this member of the health team plays an important role in making discharge arrangements.

3.3 Were your Relatives or Friends told of the date of your Discharge?

This question was asked to ascertain the amount of family involvement when giving information about discharge. Although 77% of friends and relatives were informed about the patient's discharge, in 52% of the cases, it was the patient himself who phoned them - frequently to request transport home.

In 30% of the patients interviewed, the ward sister had spoken to the family and friends to counsel them regarding the patient's care at home. The family had only had contact with the doctor regarding aftercare advice, in 14% of the cases. Thus, the ward sister appears to be the member of the health team who has the greatest access to the patient's family and friends.

3.4 In reply to "When were they told?"

Sixty-four percent of the patient's family/friends were informed of the patient's discharge on the day he was sent home. Twenty-seven percent were given information the day prior to discharge.

3.5 Patients' opinion about their length of stay in Hospital

It is impossible in a survey such as this to assess scientifically whether the patients were retained as in-patients longer than their medical condition demanded. Discussion with the medical and nursing staff does suggest that elderly patients are often kept longer because of difficult social circumstances. It was felt that the patients' opinions about their length of stay in hospital might be of interest, especially those patients who felt that their discharge had been premature. This seems to indicate a need for further support, and is thus relevant to the study.

Discharge date was:-

Too soon	14%
About right	80%
Could have been earlier	6%

In reply to the question, "Now that you are home, what do you feel about your discharge date? Do you feel it was:-

Too soon	17%
About right	78%
Could have been earlier	4%

This question was asked under the assumption that patients often feel anxious to return home whilst in the confines of the hospital, and thus overestimate their ability to cope on discharge. This

was confirmed by a small percentage of patients who felt at the time of discharge that they were ready, but in retrospect considered the discharge premature.

4. Transport home from Hospital

The majority of patients (i.e. 82%) were able to organise their own transport home. 81% of the patients had a friend or family member who came to fetch them in a car. Only one patient caught public transport home. When asked whether or not private transport arrangements had been adequate, only 4% complained that it had been inadequate. These patients were generally very ill, bedridden patients, who had had to be carried from the car to their homes.

Of the 18% of patients who had used hospital transport (i.e. 31 patients) 13% complained about the service. Comments which were recorded were:-

"It was like a nightmare".
"I had to wait for hours in the front, and was in pain".
"I waited for three hours, and was very uncomfortable during the trip home. The driver swerved and bumped the vehicle. I was in a lot of pain".
"I couldn't stand the shouting and smoking".
"It was so tiring".

5. Home Conditions

5.1 In reply to the question, "How many people are there in your household?", it was found that:-

20% of the patients lived alone
50% of the patients lived with one other person
19% of the patients lived with two other people
5% of the patients lived with three other people
6% of the patients lived with more than three other people

The 20% of patients who lived alone were in a much more vulnerable positions as regards daily living activities during their convalescence. 40% of the 35 patients who lived alone had no one to help them settle on their discharge from hospital. This meant that they had no assistance in obtaining basic requirements such as food on their return home.

Of the 50% of patients who lived with one other person, the majority lived with a spouse. In several circumstances the spouse was elderly and dependent upon the patient for care, and thus could not always be regarded as a means of support.

5.2 In reply to the question, "Who cared for you when you first came home?", it was found that:-

7% had no one to care for them
81% were cared for by a relative
3% were cared for by a neighbour
8% were cared for by a friend
1% were cared for by a district nurse

The interviewer found on several occasions, that that "care" by neighbours or friends was inadequate or minimal. One bedridden patient was visited once a day by a neighbour, who brought her something to eat. She had great difficulty using the commode, and was unable to care for herself.

6. Measurement of Incapacity at the time of Discharge

A mobility scale was used to assess each patient's mobility and dependence upon others for assistance. The following activities were evaluated:-

6.1 Getting in and out of bed

10% of the patients had difficulty
12% were unable to manage without help

Total - 22% of population

6.2 Getting to or using the toilet or commode

13% had difficulty
12% were unable to manage without help

Total - 25% of population

6.3 Having a bath, shower or "all-over wash"

16% had difficulty
20% were unable to manage without help

Total 36% of population

6.4 Dressing

13% had difficulty
15% were unable to manage without help

Total 28% of population

6.5 "Putting on shoes and socks"

10% had difficulty
16% were unable to manage without help

Total - 26% of population

6.6 "Feeding yourself"

5% had difficulty
6% were unable to manage without help

Total - 11% of population

6.7 Women - "Combing your hair")
Men - "Shaving")

10% had difficulty
6% were unable to manage without help

Total - 16% of population

Thus, it was evident that in personal and toilet activities, over a third of the patients (36%), had difficulty in bathing or washing. 25% of the patients had difficulty in dressing and getting to the toilet.

6.8 Considering these relatively high levels of disability, the next question was an attempt to evaluate whether or not the patient's dependency level was assessed when planning for his discharge. In reply to the question, "Did anyone at the hospital ask you how you would manage when you

got home?", 63% of the respondents replied in the negative, whilst 4% could not remember. Only 33% of patients replied in the affirmative.

In the group of 33% who had been counselled regarding their ability to cope on discharge, the person who assumed the responsibility was:-

Doctor	43%
Ward Sister	38%
Nurse	13%
Social worker	6%

7. Continuation of Treatment

85% of the patients who were discharged, were sent home on continued treatment. The therapy ordered was as follows:-

Medicine/Tablets	70%
Injections	1%
Dressings	2%
Nose/Ear/Eye/Drops or Spray	1%
Medicine and Injections	1%
Medicine and Dressings	5%
Medicine and Drops/ Inhalants	5%
Not applicable	15%

TABLE 7 - TREATMENT CONTINUED FOLLOWING DISCHARGE

The person responsible for giving the patient information regarding treatment was as follows:-

Doctor	39%
Ward Sister	38%
Nurse	2%
Pharmacist	1%
No one	6%
Written instructions only	14%

TABLE 8 - PERSON RESPONSIBLE FOR GIVING THE PATIENT INFORMATION REGARDING CONTINUED TREATMENT

In reply to the question as to whether or not the instructions regarding the treatment was clear or not, 31% of the patients who had received written instructions only, complained that they had been confused. Of the 125 patients who had been given instructions verbally, only 7% complained that these had been confusing.

31% of the patients on continuing therapy on discharge felt that they needed help with this treatment. In most instances this help was provided by a member of the household (56%), 9% employed a person to assist them with their treatment. Only 1 patient was actually referred to a district nurse for guidance with her treatment. 25% of the patients who felt that they needed help did not receive the required help. The two postmastectomy patients relied on the services of their G.P. for the renewal of their dressings.

When asked whether there was anything which worried them about their treatment, 19% replied in the affirmative. The concerns which they expressed were varied. Many expressed concern over their ignorance of the side effects of their medication. Others needed guidance as to the control of their pain. Questions regarding insomnia, dyspnoea, and diet were frequent. Diabetic patients, especially those on insulin, and patients who were on anticoagulant chemotherapy seemed most anxious about the monitoring of their treatment. Patients receiving radiotherapy were frequently anxious regarding the side effects of the treatment. Several patients expressed the fear that they were confused about follow-up of thei treatment.

The general impression obtained was that insufficient time had been spent with the patient, discussing both his condition and his treatment regime. Perhaps the level of anxiety which hospitalisation causes, requires medical and nursing staff to adhere to a planned programme of patient education.

8. Follow-up

94% of the patients who were discharged had been given a follow-up appointment. 6% of the patients who had been given a follow-up appointment did not attend this appointment. Either the patient was too ill to attend, or had transport problems. Hospital transport is provided for appointments at the Out-patients' Department, but some patients

complained that the transport came too early and was most uncomfortable. These complaints were in a minority. In some cases the patient's relatives kept the appointment, usually to obtain a supply of medication.

9. The Role of the Social Worker

The social worker is a key person in liaising between the patient in hospital and the community, and is instrumental in solving problems related to housing, pensions, etc. The medical and nursing staff are the people most in contact with patients whilst in hospital. They are thus more likely to identify patients with social problems. Many patients are reticent about asking for services which are not offered, or are unaware of the services which are available. It is for this reason that the availability of services needs to be explained when social problems are suspected.

Only 7% of the respondents were referred to a social worker. The reasons for this consultation were:-

Pension and Finance	1
Housing	4
Personal	3
Other	4

10. Referral to Community Services

Only 8% of the patients interviewed were referred to any community service following discharge. 50% of

the referrals which were made, were made to the Day Hospital District Nursing Service (7 patients). Six of the referrals were made by the hospital, while one patient had contacted the District Nurse herself. All 7 patients had complicated dressings which needed care.

Of the remaining 7 patients referred to a community service, 5 were referred to a social worker, and two patients were referred to "Meals on Wheels".

In reply to the question, "Did you feel that the hospital personnel did all they could to help you return to your normal routine at home?", 76% replied in the affirmative, 20% in the negative, and 4% were unsure.

11. Residual Incapacity

An attempt was made to evaluate how well the patient had recovered since discharge.

23% of the respondents interviewed had not left their homes since their return, whilst 7% remained confined to bed.

12. Evaluation of Discharge Planning

The interviewers were then asked to assess whether or not they considered that the patient had been adequately supported rehabilitively following discharge. This assessment tended to be most conservative, as the interviewers were familiar with the paucity of community resources. If a family had problems, but appeared to be coping, the patient was considered adequately supported.

Conservatively, it was estimated that 34% of the patients interviewed needed some kind of domiciliary support. Only 8% had received any kind of community care.

The patients in greatest need of domiciliary care were patients who lived alone, or with an aged spouse or friend. Patients who had been treated for a terminal illness, or a condition which led to increasing disability, were particularly in need. Cancer patients and their families freely expressed their anxiety regarding basic nursing care. Many of the interviewers found the period following the interview most rewarding, as time could be spent counselling the patient and his family regarding care. It seemed obvious that although the physical care of this group of patients might appear adequate, their need for emotional support was not being fulfilled.

A group of patients who appeared to be sadly neglected in the community was patients discharged following cerebrovascular accidents. None of the patients interviewed with this disabling condition had been referred to occupational therapy, physiotherapy or speech therapy following discharge. The lack of rehabilitative planning led to preventable complications.

Several patients would have benefited from extra equipment to facilitate rehabilitation in the home, e.g. equipment to facilitate a disabled person visiting the toilet, bathroom or kitchen. The invaluable services of the Occupational Therapy Dept. were not being utilised to their fullest extent.

None of the 172 patients interviewed had been referred to this Dept., which is significant, considering 36% of the respondents had difficulty with everyday living activities.

Neither of the two patients, who had been discharged following a mastectomy, had been referred to the supportive service "Reach for Recovery".

An obvious lack of awareness of voluntary organisations providing services such as "Meals on Wheels", "Home Help" Services, St John Ambulance nursing service, was evident.

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PART TWO

CHAPTER 5

DISCUSSION OF FINDINGS

The aim of this descriptive research project is to ascertain the nursing needs of white geriatric patients on discharge from Groote Schuur Hospital, and evaluate how effectively these needs were being fulfilled by the community services.

When considering the results of the survey, it is important to bear in mind its very limited scope. Groote Schuur Hospital is a curative health care institution administered by the Cape Provinicial Administration. Patients referred to Groote Schuur Hospital are usually either indigent, or require specialised treatment.

Only patients who were admitted for 48 hours or longer, were included in the group to be interviewed. When establishing this as a criteria for inclusion in the group, it was felt that patients admitted for less than 48 hours would have had such a transient experience of hospilisation, that rehabilitation following discharge would present few problems. Further clinical experience in Medical Casualty disproved this assumption. Aged patients with chronic illnesses are frequently admitted to Medical Casualty for acute treatment leading to relief of their symptoms and the stabilisation of their physical condition. The crisis in their chronic illness is frequently precipitated by social factors or non-compliance of treatment. The brief sojourn in Medical Casualty does not allow the staff sufficient time to investigate the social factors which underlie the patient's physical condition. A number of

patients admitted to Medical Casualty are victims of cerebrovascular accidents. These patients are seldom transferred to the medical wards of the hospital. The policy is to provide them with the necessary naso-gastric tube and catheter, and return them to their family for nursing care. Frequently, there is inadequate time and staff to investigate their home and family situation. The family is left the responsibility of the nursing care without adequate instruction or support.

One circumstance which might have affected the outcome of the survey was the variation in the interval between the patient's discharge from hospital and the interview. The interviewing was conducted in late May and early June, whereas some of the patients had been discharged early in March. Their capacity to remember circumstances surrounding their discharge may have been limited by this interval between the event and the interview. More reliable results would have been obtained had each patient been interviewed within a fortnight of his discharge from hospital. For logistic reasons, this was impossible to organise at the time.

Another factor which might have affected the reliability of the response was the number of interviewers. A group of thirteen registered nurses conducted the interviews in the patients' own homes. These registered nurses were completing a diploma in Community Health and had been given extensive instruction on interviewing technique. The interview was a rigidly structured questionnaire. However, the relatively large group with variation in personality and techniques of communication, may have led to inconsistencies in response.

The interviews were not necessarily held privately. A third person, frequently involved in the patient's care-taking, was present, and therefore contributed to the response. It is difficult to evaluate how much the presence of a third person, with whom the patient had a significant relationship, may have modified the response obtained.

The Measurement of Incapacity

A list of six activities was used as a basis for measuring incapacity. The activities were all personal and included toilet activities, which would be applicable to each respondent. The list did not include any household tasks such as preparation of food, catering or cleaning. As 20% of the respondents actually lived on their own, inability to perform this type of task must be regarded as "incapacity".

In 68% of the cases, the hospital staff had not evaluated the level of the patient's disability on discharge, and correlated it with his home situation. A relatively minor degree of incapacity is tolerable in a patient who lives on his own. The interviewers were distressed by a few cases of gross neglect. One patient was bedridden with chronic obstructive airways diseases. She lived on her own in poor circumstances. She was severely incapacitated due to dyspnoea, and relied on the daily visit of a benevolent neighbour who brought food and assisted her with the bedpan. This patient had not been referred to any community resources. A home help scheme and meals-on-wheels would have alleviated her domestic situation.

Although these cases were not frequent, the few that there were made a lasting impression!

The Continuation of Treatment

Eighty-five percent of all patients discharged were sent home on continued treatment. Most of these patients had to continue a chemotherapeutic regime. Unfortunately, no attempt was made by the interviewers to evaluate their compliance. In a survey of 450 patients at the Johannesburg Hospital [10] it was estimated that approximately 60% of all patients did not adhere to their chemotherapeutic regime. Compliance was regarded as taking between 80% and 109% of the prescribed drugs. Patients who did not comply complained of a lack of information regarding the drugs from the medical and nursing staff. Fourteen percent of the patients in the survey were given no verbal, only written instructions, as regards their treatment regime. 31% of this group complained that they had been confused as how to continue with treatment.

Non-compliance also increases with the following factors:-

* Prescribing more than two types of medication
* Including a 4-times-a-day regime
* Removing the tablets from the original container [10]

These factors were present in most of the patients interviewed. Considering that non-compliance to a treatment regime is one of the major factors leading to rehospitalisation following failure of therapy, and is consequently an economic drain on resources, every effort should be made by the hospital staff to assist the patient to comply. Geriatric patients tend to be a little forgetful. Frequently, the nature of their chronic illness necessitates multiple prescriptions. For these reasons, it might be advantageous to introduce a unit dose pack system,

or give the patient explicit instructions as how best to organise his tablet taking.

Twenty-five of the patients interviewed, who felt that they needed assistance with their treatment on discharge, did not receive it. A further 19% were anxious about aspects of their treatment, e.g. side effects of medication, diet control, etc. These patients were confused as who to contact for advice. The ward sister, or person responsible for discharging the patient, would allay many of these problems if she gave the patient written instructions as who and how to contact help - if problems arose.

The general impression obtained was that insufficient time had been spent with the patient, discussing his condition and the prescribed therapy. Perhaps, because of the patient's heightened anxiety he forgets some of the information which has been given. This difficulty might be overcome if the medical and nursing staff adhered to a planned programme of patient education. The programme should be formulated on admission as part of the nursing care plan. A nurse or sister may be allocated the responsibility of ensuring that the patient and his relatives have a grasp of all necessary details. This planned programme of patient education is most effectively used in the Coronary Care Unit.

Referral to Paramedical Staff

The survey revealed that paramedical staff were insufficiently involved in the planning for a patient's discharge. The most neglected member of the health team appears to be the

occupational therapist. Over 25% of the patients interviewed were incapacitated in daily living activities, some due to fractures, hemiplegia, etc. Yet none of the 172 patients interviewed had been referred to an occupational therapist for assessment, advice regarding aids, or rehabilitation. The occupational therapist is a vital member of the health team, especially when caring for patients with chronic and disabling disease, and the neglect to refer to her for expert advice disadvantages the patient.

The medical social worker is a key person in liaising between the patient in hospital, and community services, and is instrumental in solving a variety of personal and financial problems. Many patients interviewed had problems in these areas, but only 7% of the group had been referred to the social worker. Many patients are reticent about asking for services which are not offered, or are unaware of what services are available. If the medical and nursing staff assess the patient's social and family environment on admission, this need would be overcome.

Referral to Community Services

The aim of the survey was to ascertain the nursing needs of aged patients, and assess how adequately these were being fulfilled in the community. Thirty-five percent of the patients selected for the study were 75 years and over, and thus could be considered relatively aged. Most (87%) were retired and on pension. Twenty percent of the group lived alone, and a further 50% lived with one other person, usually a spouse. In many circustances, the spouse was

also elderly and dependent upon the patient for care, and could not always be regarded as a means of support. Twenty-five percent of patients discharged could be considered incapacitated by their illness, and were dependent upon others for assistance in personal and toilet activities. Thirty-six percent of the patients discharged had problems with washing and bathing.

Over half of the patients in the study either needed no aftercare, or were receiving adequate help from family and friends. Thirty-four percent needed nursing care that they were not getting. Usually the need was for both basic nursing care and for advice and reassurance. The practical nursing needs were usually simple, and entailed things like assisting with bathing, dressings, injections and household activities. The range of counselling required was frequently more complex. Patients needed more information regarding their illness, side effects of treatment, the relief of symptoms and control of pain. Advice concerning activity was predominant. Patients were confused as to how much they were supposed to do when told to "Take it easy".

Practical modifications of living conditions, which could facilitate greater mobility, were frequently obvious to the eye of a trained nurse. Patients needing home nursing equipment, such as bedpans, commodes, wheelchairs, etc., were often ignorant of the fact that these items could be hired.

It is probable that many of the patients received adequate advice whilst in hospital. However, following discharge, the instructions became blurred and confused. Verbal instructions if accompanied by written instructions would

solve this problem. A follow-up visit, by a student nurse or trained sister, following discharge would give the patient the opportunity to ask questions and clarify instructions. The critical time for the patient and his family is the first 48 hours folowing discharge. The home visit would only be indicated in patients who could be classified as "vulnerable" on discharge, i.e.

* Aged patients
* Chronically ill
* Patients who live alone or without adequate home support
* Patients whose illness has led to a disability
* Patients who have had a prolonged period of hospitalisation.

The purpose of the home visit would be to ensure good continuity of care, and to check that the patient was adequately referred to the community resources.

The Discharge Procedure

The decisions that are made which affect what takes place at the patient's discharge are not easy to identify. There is no set time when arrangements are made. Although the decision concerning discharge may be initiated by any member of the health team, it is usually the doctor who makes the decision regarding discharge date. The research survey revealed that 52% of the patients were only told of this intention the same day of discharge. A further 26% were given one day's notice. In 87% of the cases, it was the doctor who gave the patient this information.

Eighty percent of the patients interviewed regarded the timing of their discharge as ideal, 14% felt they had been

sent home too soon, and 6% considered that their period of hospitalisation had been unnecessarily prolonged. However, when asked to view the timing of their discharge in retrospect, a further 3% confessed that they had overestimated their strength in their desire to return to their own home environment.

A patient's perception of his home situation may vary from that of his family and friends. In his eagerness to go home, a patient may assume that a friend or family member will be willing to care for him on discharge from hospital, with realising the difficulties involved. The family members or friends may be anxious, or feel incapable, of the responsibility. Unfortunately, it does appear from the survey, that the family is inadequately counselled by the hospital staff, prior to the relative's discharge. Only 25% of the patient's families or friends were actually told of the discharge plans by the hospital staff. It appears that the ward sister has the greatest contact with the patient's family, and thus should be responsible for assessing their attitudes and capabilities.

Assessment of the Patient's Social Background

In considering the social aspects of patient care, a useful concept is that of a social diagnosis, i.e. a synopsis of the patient's home and social circumstances. This must be used as a criterion when making the decision as to whether to refer the patient to supportive services in the community or not. The social diagnosis runs along the medical diagnosis, at times overlapping it, but not being part of it. Both are units of a whole in that they are different aspects of the same patient. (2 p565)

The social diagnosis is regarded differently by different categories of health professionals. The facts seem to suggest that the medical staff regard social aspects as secondary to medical factors. When the acute phase of the illness is over, social aspects are considered merely in order to facilitate discharge.

The houseman takes a brief social history from the patient on admission to hospital. At this time he may also see the relatives. If any obvious problems appear at this time, he will usually mention them to his seniors, who will consider a referral of the patient to paramedical staff, e.g. the medical social worker.

Nurses come into contact with the patient more frequently and on a more informal basis than do doctors. The more junior and untrained staff have the greatest contact time with the patient and his family. Does the invaluable information gained by these nurses get effectively passed up the hierarchy to the ward sister? Is this even encouraged? Do the junior nurses appreciate the importance of what is revealed to them informally by the patient?

The nursing staff at Groote Schuur do not, in general, use a problem orientated approach when planning nursing care. An attempt to introduce this effective approach was attempted during 1979, but due to nursing staff shortages and the heavy pressure of work, did not become fully implemented in the ward situation. In a problem orientated approach to nursing care, i.e. the Nursing Process, a documented assessment of the patient's social circumstances as is relevant to his condition, is made on admission. This assessment pinpoints problems which will

ensue when planning for continuation of care following discharge. The early social assessment leaves adequate time to make referrals to paramedical staff and community resources. A planned programme of patient education is also initiated at an early stage, and a nurse allocated the responsibility of gradually counselling the patient and his family in all aspects of care.

A social assessment should be two-fold. Firstly, the nurse should assess the patient's functional ability, i.e. the affect of the disease on the patient and his performance. The evaluation of the following factors is useful when determining how dependent the patient is on others for his care:-

* mental ability
* urinary and faecal continence
* visual ability
* hearing
* speech
* mobility
* ability to eat, dress and wash independently

Secondly, the patient's support system of family and friends must be assessed to ascertain whether or not he should be returned to his own home for care. Frequently, an elderly patient who has poor functional ability may be successfully returned to a supportive family, while, on the other hand, a moderately disabled patient, who is socially isolated, may need maximum support from the community services.

A student nurse with the guidance of the ward sister or clinical instructor, would be the best person to do this type of assessment. The process would prove invaluable in numerous ways. Continuity of care would improve as the nurse would gradually become aware of the extent of services available for support in the community. She would gain experience in a problem solving approach to nursing care rather than a task orientated approach and would thus gain insight into the multifaceted approach to patient care. The responsibility of having a patient allocated to her for assessment would make an excellent learning experience, and provoke initiative in the young nurse. If the nursing care case study could include a home visit following discharge, an optimum learning situation would be achieved. The time spent on a home visit could be considered as part of the South African Nursing Council's compulsory clinical experience in community health.

Summary

Thirty-four percent of the patients interviewed in the survey were not getting the nursing care and support in the community which they needed to facilitate rehabilitation. The most vulnerable patients as regards aftercare needs tend to be:-

* the aged
* chronically ill patients
* patients who live alone or without social support
* patients whose illness leads to a temporary or disability
* patients who are hospitalised for longer than 14 days

The aftercare needs of the chronically ill, aged and disabled patients admitted for acute care in Medical Casualty must not be overlooked. Support is most critically needed in the first 48 hours following discharge.

Problems regarding the aftercare of vulnerable patients could be alleviated if a problem orientated approach to nursing care was implemented by the nursing staff at Groote Schuur Hospital. An assessment of the patient's functional ability and social environment should be made soon after admission to hospital. Once nursing problems have been defined, a nursing care plan may be formulated to facilitate optimum care for the patient. This approach would lead to the early referral of patients with problems to paramedical staff who could give them specialised assistance with these aspects of their care.

Part of the nursing care plan would incorporate preparation of the patient for discharge from hospital. A planned programme of patient education could be initiated for relevant patients during which patients would be given information regarding their illness, the relief of symptoms, the side effects of treatment and the control of pain. At this time, problems regarding the patient's discharge and continued treatment in the community, would also be considered. Adequate warning of the potential date of discharge must be given to both the patient and his family if at all possible. Verbal instructions, accompanied by written instructions, should be given to a patient who is continuing his treatment at home. Included in this list of written instructions should be the name and phone number of a person to contact, if the patient experiences any problems.

The nurse, because of her role, and her close association with the patient and his family, would be the best person to co-ordinate all discharge arrangements. A discharge checklist and instruction sheet for the patient (Appendix 2 & 3) could facilitate the task.

Nursing care planning, incorporating discharge, planning and liaison with community services, would be an ideal mode of clinical teaching of the nursing student. If this case study could include a home visit following the patient's discharge, the student nurse would be exposed to total patient care in practice.

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PART TWO

CHAPTER 6

A SURVEY OF THE ATTITUDES OF WARD SISTERS TO AFTERCARE PLANNING

This chapter describes the results of a questionnaire used to assess the attitudes which ward sisters had as to the importance of their task in facilitating the aftercare of patients discharged from hospital.

A number of aftercare studies have made the assumption that the ward dister plays a vital role in making the preparations for a patient's transfer from hospital to home. This assumption was supported by the results of the survey of aged patients discharged from Groote Schuur Hospital. (Chap 5, 3.3)

How do ward sisters see their role in aftercare planning? Do they regard the facilitating of continuity of care as one of the main objectives of good nursing, or is discharge planning merely regarded as a set of routine administrative tasks such as obtaining the prescription of drugs for patients to take home, making transport arrangements and arranging a follow-up appointment? If continuity of care is the ward sister's objective, then ideally her functions should include:-

* Detailed explanations of aftercare arrangements with the patient and his family
* Referral to the medical social worker when necessary
* The organisation of various discharge and aftercare services

* Liaison with the community services when necessary

From informal discussions with the nursing staff at Groote Schuur, it was ascertained that the ward sisters expressed a wide range of opinions as to the importance of their role in discharge planning. There also appeared to be a wide variation as to the importance of this responsibility in relationship to other pressing tasks. The ward sister has a wide range of functions. She is ultimately responsible for the administration of her unit, the clinical nursing care of her patients and the education of the nursing staff subordinate to her. These disparate functions are integrated, but priority placed on each task will determine how the ward sister functions professionally.

A list of ten functions, regarded as the main responsibilities of the ward sister working in a clinical situation was drawn up by Ida Roberts (1 p. 89-90). One way of testing the ward sister's orientation to her role in the hospital, would be to assess the differences in attitudes, and by inference, differences in practice to these ten functions. The principal objective of such an exercise would be to discover any variation in the degree of importance attached to each function.

The Survey

A questionnaire, listing the following ten functions of a ward sister, was compilied. (Appendix 4)

A. All charts and records are accurately kept and up-to-date.

B. Bed utilisation is good, e.g. Admissions are rarely held up because beds are "blocked" by patients.

C. Patients' relatives and other visitors have reasonable opportunities to obtain information or discuss particular problems with the staff.

D. The medical staff can rely on treatments and medication being given according to their instructions.

E. The domestic work is well organised and the ward always looks bright and clean.

F. Nursing equipment and drugs are always in good order.

G. Emergencies are dealt with calmly and without undue disturbance of ward routine.

H. When patients are discharged they are able to carry on at home and readjust with the least possible difficulty.

I. Students and/or pupil nurses receive adequate teaching and supervision.

J. All clerical work is efficiently and competently dealt with.

The survey was conducted during one of the regular meetings of ward sisters in the hospital at which the study of discharged patients had been carried out. The questionnaire was distributed to the ward sisters at the meeting. Simultaneous administration of the questionnaire ensured that it was introduced to each participant in identical terms, and in the same circumstances, and minimised the risk of collusion between the respondents. None of the ward sisters were aware that a study of aftercare was in progress. The topic of aftercare was not mentioned during the administration of the questionnaire. Although the hospital matron chaired the meeting, the introduction and explanation of the proposed survey was left entirely to the researcher. The meeting was attended by every ward sister on duty who was currently working in the in-patient facilities of the hospital.

The ward sisters were told that the enquiry was part of a study on the responsibilities of ward sisters within a larger project concerned with nursing care. They were asked to consider the items listed, and rank them in order of priority in relation to their current working situation. 10 was the most important function, and 1 the least important. It was emphasised that no "right" or "wrong" answer existed, as the rating of priorities of function reflected the ward sister's personal views. As it was recognised that priorities could change from time to time in varying circumstances, respondents were asked to complete the questionnaire quickly, giving a spontaneous general opinion. The fact that their replies were anonymous and entirely confidential was emphasised. The questionnaires were completed and returned before the general meeting commenced.

TABLE 9 (Appendix 4)

QUESTIONNAIRE - THE RESPONSIBILITIES OF WARD SISTERS

Ranking of items in their order of importance for the care of patients by all respondents (N = 33)

N	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
A	6	6	8	7	8	8	10	8	7	9	7	6	6	10	8	10	10	4	10	7	7	4	8	3	6	8	10	3	6	10	6	9	9
B	5	3	4	8	2	5	3	5	1	7	2	5	2	1	5	4	2	7	2	2	1	10	6	4	2	4	2	2	1	2	2	7	10
C	4	4	7	2	3	4	2	6	8	6	6	9	4	5	3	7	4	6	3	10	10	8	2	6	3	2	6	1	2	4	5	2	4
D	7	1	10	10	10	9	6	10	10	1	10	10	10	7	10	8	7	5	7	8	8	5	9	9	8	10	9	7	8	9	9	10	7
E	3	10	2	3	4	1	5	7	5	8	3	2	3	2	2	6	3	1	1	3	6	6	3	2	1	3	5	6	3	3	4	3	2
F	8	5	9	5	7	7	7	2	4	2	5	4	9	6	6	5	9	3	8	5	2	3	7	5	10	9	8	5	9	8	7	4	3
G	9	2	5	9	6	10	4	3	3	5	8	3	8	3	7	2	8	10	4	4	5	1	10	10	9	6	7	8	10	6	8	6	6
H	2	8	6	4	5	3	1	4	9	4	4	8	7	9	4	9	6	9	6	9	4	7	4	8	5	5	1	10	5	5	3	8	5
I	10	7	3	6	9	6	9	9	6	3	9	7	5	8	9	3	5	8	9	6	9	2	5	7	7	7	4	4	7	7	10	5	8
J	1	9	1	1	1	2	8	1	2	10	1	1	1	4	1	1	1	2	5	1	3	9	1	1	4	1	3	9	5	1	1	1	1

TABLE 10 (Appendix 4)

QUESTIONNAIRE - THE RESPONSIBILITIES OF WARD SISTERS

* Percentage of ward sisters' rating of score items A-J

LEGEND

Score	A	B	C	D	E	F	G	H	I	J	
1	0	12%	3%	6%	12%	0	3%	6%	0	58%	A
2	0	33%	18%	0	18%	9%	6%	3%	3%	9%	B
3	6%	6%	12%	0	33%	9%	12%	6%	9%	6%	C
4	6%	12%	21%	0	6%	9%	9%	21%	6%	6%	D
5	0	15%	6%	6%	9%	21%	9%	18%	12%	6%	E
6	21%	3%	18%	3%	12%	6%	15%	9%	12%	0	F
7	15%	9%	6%	18%	3%	15%	6%	6%	21&	0	G
8	21%	3%	6%	15%	3%	12%	15%	12%	9%	3%	H
9	9%	0	3%	18%	0	15%	9%	15%	21%	9%	I
10	21%	6%	6%	33%	3%	3%	15%	3%	6%	3%	J
Median Score	8	3	4	9	3	6	6	5	3	1	

* Percentage given to the nearest decimal point

TABLE 11

QUESTIONNAIRE - THE RESPONSIBILITIES OF WARD SISTERS

An Analysis of the Ward Sisters' rating of the order of importance of their responsibilities using the median value of

NURSING RESPONSIBILITY

		MEDIAN VALUE
D.	The medical staff can rely on treatments and medication being given according to their instructions.	9
A.	All charts and records are accurately kept and up-to-date.	8
I.	Students and/or pupil nurses receive adequate teaching and supervision.	7
F.	Nursing equipment and drugs are always in good order.	6
G.	Emergencies are dealt with calmly and without undue disturbance of ward routine.	6
H.	When patients are discharged they are able to carry on at home and readjust with the least possible difficulty.	5
C.	Patients' relatives and other visitors have reasonable opportunities to obtain information or discuss particular problems with the staff.	4
B.	Bed utilisation is good, e.g. Admissions are rarely held up because beds are "blocked" by patients.	3
E.	The domestic work is well organised and the ward always looks bright and clean.	3
J.	All clerical work is efficiently and competently dealt with.	1

Results

The main objective of the survey was to discover from the data, the relevant importance which the ward sisters rated their task of facilitating aftercare for the patient being discharged. The survey response is set out in Tables 9, 10 and 11.

One statement related directly to discharge and aftercare planning, i.e. 'H', "When patients are discharged they are able to carry on at home and readjust with the least possible difficulty". Another statement, 'C', "Patients' relatives and other visitors have reasonable opportunities to obtain information or discuss particular problems with the staff", was indirectly related to the topic. These two statements were given a medium value of 5 and 4 respectively. (Table 11) The results showed considerable variations in opinion. 15% of the ward sisters rated aftercare planning very low in their priority list, whilst 30% rated it very high. A similar range of opinions existed in the rating of the importance of adequate communication with the patients' relatives and visitors.

Discussion

The statement about discharged patients was embedded in a list that included statements about tasks likely to be seen as the constant and inescapable responsibility of any ward sister, matters such as treatments, medication, and the maintenance of accurate and up-to-date records. It would therefore be very difficult to assess the priority of a variety of responsibilities. If the state of after-care might be perceived as an end product to which all

aspects of ward care contribute, it would be reasonable to assign a high value to it. The ward sisters who took part in the survey were not offered time in which to consider the distinction between proximal and ultimate ends. They were faced with a list of items that were of immediate pressing importance in their own sphere of work. It was therefore not surprising that these tasks, which form the core of the ward sisters' daily routine, tended to be ranked above the issue of aftercare. A ward sister is immediately accountable for the running of the ward, but not for the well-being of people whose current care is no longer within her direct control.

Over 50% of the ward sisters rated the importance of planning aftercare of relatively minor importance. Others rated it high on their list of priorities. There is thus a great variation in the attitude to aftercare planning amongst the ward sisters at Groote Schuur Hospital.

Effective aftercare planning affects the long-term management of chronically ill patients. It might thus be advantageous to include it as a topic to be discussed during inservice training programmes for the ward sisters at Groote Schuur Hospital. By exposure to many of the patients' problems following a period of hospitalisation, and given the scope of facilities which exist in the community which could alleviate these problems, the ward sisters may be able to make an increased contribution to planning the continuity of care of patients admitted to their units.

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1. Roberts, I., (1975) Discharged from Hospital, R.C.N. and National Council of Nurses of the United Kingdom, London, Series 2, No. 6.

PART THREE

CHAPTER 7

THE COMMUNITY RESOURCES FOR RECENTLY DISCHARGED GERIATRIC PATIENTS

EXISTING COMMUNITY SERVICES

The pluralism and complexity of the South African health system makes it difficult to undertake a wholistic assessment of the problems in providing comprehensive health care to the aged and chronically ill members of the population. It is particularly difficult to evaluate the domiciliary health care systems, as although they may be located in the same geographical area, they frequently function in isolation to one another. The lack of co-ordination and communication results in the duplication of some services, and the omission of others. The health services have not developed in a co-ordinated manner due to the lack of a uniform policy in the administration of community health and hospital services. The fragmentation of health care provision is due to political events which have shaped the historical evolvement of governmental policy.

The Historical Development of Health Policy in South Africa

Prior to the Union of South Africa in 1910, the four colonies functioned independently, each with its own set of health laws. Initially, the responsibility for dealing with outbreaks of infectious diseases and other health matters lay with the colonial governments. Later legislation led to the establishment of local authorities who were entrusted with the responsibility of controlling

sanitation and health in their respective areas. The establishment of hospitals, and the control of health at the ports remained the responsibility of the colonial governments.

In 1910, the National Convention led to the amalgamation of the four colonies into the Union of South Africa. The colonial governments became the Provinical Administrations. They were delegated some of their former functions such as the control of local government, i.e. the Municipal and Divisional Councils, the establishment of hospitals, and the control of charitable institutions.

Little provision was made in the legislative machinery for the protection of public health until 1919, when the Public Health Act No. 36 of 1919, was passed. The passing of this legislation led to the establishment of a central health authority, now the Department of Health. The fundamental principle embedded in the 1919 Public Health Act was that of decentralisation. Delegated to the Local Authorities was the responsibility for the control of infectious diseases and environmental sanitation. The Provincial Administration's retained their responsibility for the implementation of curative health care. The Public Health Act of 1919 thus dividied health functions between the Department of Health, the Provincial Administrations and the Local Authorities.

In the six decades since the promulagation of the Public Health Act of 1919, the health needs of the country have changed. With the advent antibiotics, infectious diseases have become less prevalent. Increasing urbanisation and

industrialisation has led to an increasing emphasis on the control of occupational health hazards. As a proportion of the population has benefitted from a higher standard of living, the diseases correlated with affluence have become increasingly prevalent. A higher standard of living and the decrease in the prevalence of infectious diseases, has led to a prolongation of lifespan. An ageing population has health problems correlated with degenerative diseases such as diabetes, chronic bronchitis, congestive cardiac disease and carcinoma. Advances in medical science has led to emphasis being placed on services in primary and secondary disease prevention.

As a result of the changing health situation in South Africa, a review and updating of the original Public Health Act of 1919 became necessary. This resulted in the Health Act No. 63 of 1977 being passed. The purpose of this new legislation was to create a blueprint for the rendering of health services by the three tiers of government, and by doing so, negate the inefficiency and overlapping of services which existed up to that point. (1)

Medical and social progress has brought about a lengthening of the human lifespan. It can therefore be predicted that there will be an increasing need for services for the elderly for many years to come. Ageing is a natural phase of life, but as the years increase, general health and vitality wane, and the old person becomes more and more dependent upon others for his care. The ideal in geriatrics is to keep the aged person living as independent and useful life in the community for as long as possible. In order to achieve this objective, the elderly require support from a multidisciplinary health team including

nurses, social workers, physiotherapists, occupational therapists, chiropodists, and voluntary organisations.

The ideal person to seek out the elderly in the community, and assess their physical, emotional and social needs, is the community nurse. Following an assessment of the aged person's health problems, it is the responsibility of the community nurse to refer relevant problems to the appropriate health agencies. The community nurse acts as a co-ordinator in the care of the aged, supporting them at each phase of health care.

The Function of the State, Province, Local Authority and Voluntary Agencies in the Care of the Aged

The Health Act No. 63 of 1977 has not yet been fully implemented in South Africa. Thus, the deployment of services as presently utilised, is described. Geriatric health and welfare services are both formal and informal. The informal services range from neighbourly friendliness to organised charitable functions such as provided by clubs, e.g. Lions, Rotary, etc. Informal services are by nature sporadic, and therefore difficult to assess. Although they are essential to the well-being of the aged person in the community, they cannot be easily documented. For this reason, only the formal geriatric health services are described.

1. The Department of Health and Welfare

State Health, acting through the District Surgeons, is responsible for providing free out-patient medical care for the indigent aged living either in their own homes,

or in old age institutions. Free medicines and appliances are supplied on prescription. A major difficulty is that in many areas district surgeons are in short supply. In these cases, general practitioners are appointed on a sessional basis to attend to the aged in some of the old age homes. (4)

The Cape Peninsula is divided into two zones, Cape Town and Wynberg. Cape Town zone has nine District Surgeons while Wynberg has seven. A further eight District Surgeons serve the Bellville zone.

Senior nursing officers employed by the Department of Health and Welfare assist in the inspection of old age homes to ensure that personal care is given to the residents. (4)

State Health provides a Geriatric Nursing Service. Seven posts for registered nurses with a specialisation in Community Health have been allocated to this relatively new service. Five of the posts have been filled by experienced Health Visitors. Three of the Geriatric Community nurses have been allocated to the Bellville area, and two to the Cape Town area. The Geriatric Community nurses are able to intervene at periods of crisis, and provide a comprehensive nursing service to the aged patients to whom they are referred. Once the period of crisis is resolved, long-term follow-up is planned.

Referrals to the Geriatric Community nurses come from the hospitals, Local Authority Health Visitors and the

Day Hospitals Organisation. The Geriatric Community nurses visit the aged, making an assessment of their physical and psychological condition. They are responsible for co-ordinating the health care for their patients ensuring that all the patients' needs are fulfilled. A health screening clinic is being organised at Pinelands Place by the State Health Geriatric Community nurses.

The service being provided by the Geriatric Community nurses is still in its infancy, and it is difficult to assess at this stage, how effectively the State Health Community Nursing Service will be able to cope with the community health needs of the aged in the Cape Peninsula. Unfortunately, due to the shortage of nursing staff, the geriatric nursing service is limited in the Cape Town area to the central city area, Gardens, Mowbray, and Pinelands.

2. <u>The Provincial Administration</u>

The Provincial Administration is responsible for providing in-patient and out-patient curative health services. This responsibility entails the organisation and administration of the Provincial Hospitals, the Day Hospitals Organisation and the supervision of the private nursing homes and mission hospitals.

In the Cape Peninsula, it is the Day Hospitals Organisation which administers the District Nursing Service. The District Nursing Service attempts to provide a domiciliary medical and nursing care in co-operation with the medical practitioners in charge

of the patients. The District Nurses are registered nurses. There are seventeen Day Hospitals and seven District Rooms in the Cape Peninsula. The establishment of twenty-five District Sisters are affiliated to these facilities, and deal with referrals from the Provincial Hospitals and the Day Hospitals. The District Nursing service focuses mainly on the needs of the lower socio-economic groups. A free service is provided to indigent patients, whereas a fee of R3,00 a visit is charged in the case of patients who are able to pay for the service. This fee is seldom levied.

During 1981, the District Nurses dealt with 72 522 consultations.

White	10 709
Coloured	53 997
Black	7 816
Total	72 522

TABLE 12 - DOMICILIARY VISITS OF THE DISTRICT NURSING SERVICE DURING 1981

The District Sisters also dealt with 17 547 consultations to the District Rooms.

According to Dick et al [3, p892] there are approximately:-

25 / 1 000	Black
37 / 1 000	Coloured
12 / 1 000	White

TABLE 13 - STANDARDISED PREVALENCE PROPORTIONS OF CHRONIC ILLNESS IN THE CAPE PENINSULA (18, p892)

According to the figures in the 1970 Census records, there are approximately one million people living in the Peninsula. This would indicate that the chronically ill, non-institutionalised patient group would be in the region of 25 000. (5) If one considers that the Day Hospitals Organisation District Nursing Service consists of an establishment of twenty-five District Nurses, there is a ratio of one district nurse per 1 000 chronically ill, non-institutionalised patients. (5) This invaluable nursing service is thus grossly under-staffed, and the District Nurses are individually under a heavy case load. This necessitates them reducing their visits to urgent cases to one visit per patient per day. Frequently visits have to be limited to three per week.

The District Nurses concentrate their efforts on providing clinical care to patients. For example, there are three District Nurses allocated to the Dr Abdurahman Day Hospital in Athlone.

Month	Visits
December	1 302
January	1 105
February	1 042
Total no. of visits	3 449

TABLE 14 - DISTRICT NURSING DOMICILIARY VISITS DURING A THREE MONTH PERIOD (1981/1982) FROM DR ABDURAHMAN DAY HOSPITAL

These three District Nurses routinely visit 60-109 geriatric patients in the Athlone area on a monthly basis. During this routine visit, the District Nurse

ensures that the patient has a repeat of their monthly medication, which is issued by the clinic. Every six months, the geriatric patients are brought to the Day Hospital for a routine medical examination by the medical staff. The District Nurses have completed a Primary Health Care course, and are competent to assess the patient's medical status in his own home in the interim.

The bulk of the District Nurses' workload consists of caring for a large group of patients with chronic varicose ulcers, supervising the home nursing of forty-five patients disabled by cerebrovascular accidents, and giving support and nursing care to a varying number of patients who are terminally ill with carcinoma. They provide routine care to eighteen patients with indwelling and supra-pubic catheters, and deal with the hospital referrals of recently discharged patients who need assistance with their aftercare.

The District Nurses are experienced professional nurses, but are frequently too pressurised by their case load to give the patient and his family the comprehensive nursing care which they would like to. Due to necessity their care may be limited to renewing a dressing, erecting traction or giving medication. Providing practical and emotional support to the patient and his family is a time consuming task. It is a pity that the pressure of work may limit this health professional to provide the type of care for which she is professionally competent.

The District Nurses complain of the lack of communication between their service and the Provincial Hospitals. Case history details are frequently omitted from the referral letters. Treatment instructions issued by the doctors, are often incomplete and insufficiently specific. Communication between the District Nurses and Groote Schuur Hospital has improved since the appointment of a Community Liaison nurse.

A patient referred to the District Nursing Service, should receive a copy of the referral letter. The original is sent by post to the Day Hospital. An early referral, preferably prior to the patient's discharge, results in the District Nurse being able to provide prompt continuity of care.

3. The Local Authorities

The Local Authorities are responsible for providing preventive and promotive health services. The services provided by the Local Authorities may be divided into personal and non-personal (environmental) services. The personal health services include antenatal and postnatal clinics, immunization clinics, geriatric clinics and family planning clinics.

Situated in the City of Cape Town are 51 clinics providing all facets of preventive and promotive care. These clinics are staffed by 130 Clinic Sisters. Clinic Sisters are registered nurses with a dual qualification in general nursing and midwifery.

The Local Health Authorities employ a further 90 Health Visitors. This establishment is calculated on the ratio of one Health Visitor for every 10 000 population. The function of the Health Visitor is to provide a comprehensive family health service. The Health Visitor visits the family in their home, assessing health needs, referring problems to appropriate services, and co-ordinating health care. Health Visitors are registered general nurses and midwives, with a further specialisation in Community Health.

Priority is given by the Local Health Authorities to Maternal and Child Health. Approximately 70% of the Health Visitor's time is allocated to matters pertaining to child health, immunization and family planning. A further 20% of their time is spent dealing with clients and their families who have contracted tuberculosis, and 5% tracing and treating the contacts of clients with sexually transmitted diseases. The remaining 5% of the Health Visitor's time is allocated to dealing with problems related to geriatrics.

The Health Visitor has a family orientated approach. While visiting a family in connection with a health matter, for instance, a new birth registration, she then investigates the health of each member of the household. Any aged family members are listed and encouraged to attend one of the sixteen Geriatric Screening Clinics in the Cape Town area.

During 1981, 1 112 aged people were screened at the Geriatric Clinics. As a result of the consultations,

health and social problems were identified. During 1981, the following referrals of geriatric patients were made:-

General Hospital	118
Day Hospital	441
Eye clinic	229
Hearing assessment	44
Dentures	112
Dental treatment	12
Psychiatry	4
Physiotherapy	4
Chiropody	647
Social problems	35

TABLE 15 - REFERRALS OF PATIENTS ASSESSED AT LOCAL AUTHORITY GERIATRIC SCREENING CLINICS DURING 1981

The Health Visitor's role is supportive and advisory. She does not undertake clinical nursing tasks, e.g. renewal of dressings, catheter care, etc. These tasks she would refer to the District Nurse. This leads to an overlapping of nursing care services. An aged patient may be visited by the State Geriatric Nurse, the Health Visitor and the District Nurse. The Geriatric Nurse and Health Visitor would give support and advice, while the District Nurse would perform the necessary clinical nursing tasks.

4. Voluntary Organisations

4.1 The Red Cross Society Home Nursing Service

Eighty-four Bantu and two Coloured nursing

assistants are employed by the Red Cross Society to attend to the basic nursing care of patients in their homes. The service functions on a daily basis from Monday to Saturday. The nursing assistants perform elementary nursing duties such as bedbaths, pressure care, assisting a bedridden patient to become ambulant, etc. The nursing assistants perform essential domestic chores. All nursing assistants employed by the Red Cross Society are registered with the South African Nursing Council. They are not qualified to perform the more technical nursing tasks, e.g. dressings, injections, stoma care or catheterisation, unless under the direct supervision of a registered nurse.

The Red Cross Nursing Service covers a large area of the Cape Peninsula from Clifton on the Atlantic side, to Fish Hoek on the False Bay side. The service is multiracial. A fee of R6,50 per day/ night is charged. This fee is exclusive of the cost of transport and a meal which the client is expected to provide.

Referrals for the Red Cross Nursing Service come from the nursing staff at the Peninsula Hospitals, Welfare Organisations, General Practitioners and family members. The Red Cross Society subsidises a free service to indigent patients for a period of up to twelve days.

4.2 St John's Ambulance Home Nursing Service

St John's Ambulance have a voluntary Home Nursing

Service staffed by six registered nurses, and twenty-four lay women who have completed a home nursing course. Volunteers for the Home Nursing Course are recruited from participants of the First Aid Course for which St John's Ambulance is well known. The registered nurses are white, while the lay home nurses are Coloured and Black.

The St John's Ambulance Home Nursing Service is rendered to the client free of charge. The organisation makes an attempt to reimburse the travelling costs of the volunteers. St John's Ambulance is a voluntary organisation which depends upon donations and fund raising activities for support.

The referrals for this service are mainly from the Community Liaison nurse and the social workers at Groote Schuur Hospital, the National Cancer Association, and Health Visitors from Local Authority.

Ninety-four patients were assisted by St John's Ambulance Home Nursing Service during the period extending from April 1981 to January 1982. Ninety percent of these patients were over the age of 65 years. It is estimated that 20% of the patients referred to this service were disabled by cerebrovascular accidents. A further 20% had malignant diseases. Most patients were chronically ill and disabled. The registered nurses were able to assist patients with the full range of their care, while the lay

volunteers limited their care to providing basic nursing care. Visits are arranged from a daily to a weekly basis. Each visit is of approximately two hours duration.

The St John's Ambulance Home Nursing Service is being utilised to an optimum capacity at present. Unfortunately, due to a lack of volunteers, there are large areas of Cape Town where the volunteers are unable to provide a service. These include Camps Bay, Sea Point, City, Woodstock, Observatory, Maitland, Brooklyn, Blouberg, Bonteheuwel and Kensington. Most of the patients who utilise this service live in areas such as Mannenburg, Retreat, Heideveld Elsies River, Southfield, Constantia and Fish Hoek.

Due to the demand for a domiciliary nursing service, plans are aloft at St John's Ambulance to expand their Home Nursing Service by employing registered nurses, enrolled nurses and nursing assistants on a part-time basis. This scheme plans to utilise a large reservoir of trained nurses who are not able to use their professional skills due to family commitments. The Cape Peninsula would be zoned, with a co-ordinator being appointed in each zone. Part-time nurses would be recruited from each zone, and each nurse allocated a small case load. The patients would be charged for their nursing care in order to reimburse the nurses for their services.

The difficulties in implementing a scheme like this are numerous. St John's Ambulance would

need financial sponsorship to establish the service. Sponsorship is still being sought. A large publicity scheme would have to be implemented in order to recruit the staff needed to co-ordinate such a large Volunteer Nursing Service. It has been estimated that approximately 80% of the patients utilising the Home Nursing Service at present, would be unable to pay for such a service.

4.3 The National Cancer Association

The National Cancer Association has a Home Nursing Service for oncology patients in the community. This scheme was commenced during August 1981. The aim of the service is to offer specialised nursing care to patients with cancer living in the community. Advice is given to the patient and his family regarding problems such as pain control, basic nursing care and the relief of symptoms. The nursing staff assess the needs of the patient and co-ordinate community resources able to fulfil these needs. They offer counselling and emotional support to the terminally ill patient and his family. This support extends into the family's bereavement in appropriate circumstances.

Twenty-five percent of the nursing load of the nursing staff entails giving guidance to patients who have stomas as a result of their illness. All stoma appliances are issued to patients at cost price. The National Cancer Association is also able to provide equipment such as wheelchairs,

urinals, bedpans, etc., to patients on loan, free of charge.

The establishment of the National Cancer Association Home Nursing Service consists of two experienced registered nurses and two social workers. The National Cancer Association is a voluntary organisation financed by bequeaths from patients and fund raising activities. All visits to patients by the staff are free of charge.

The Home Nursing Service of the Cape Town Branch of the National Cancer Association is relatively new, and the staff are active in publicising their existence to individuals who might be in need of their services. Patients are referred from various sources, mainly:-

* General Practitioners
* Provincial and Private Hospitals
* Social workers from various agencies
* Friends and relatives of the patient

The nursing staff of the National Cancer Association complain that referrals from general practitioners and nursing staff are generally accompanied by insufficient information regarding the patient's condition, treatment and social environment. This makes the planning of comprehensive nursing care difficult. Patients tend to be referred very late in their illness, when the problems regarding their home care have become oppressive to their families and friends. Early consultation would allow better planning and support of the

patient and his family. Ideally, referrals to the National Cancer Association Home Nursing Service should be arranged prior to the patient's discharge from hospital.

The Home Nursing Service at the National Cancer Association could support approximately 30-40 oncology patients in the community. They are able to cope with more referrals than they are presently receiving. Although the National Cancer Association orientates its care specifically towards clients with malignant diseases, they are providing a vital and comprehensive service in the community.

4.4 Cape Peninsula Welfare Organisation for the Aged

The Cape Peninsula Welfare Organisation for the Aged (C.P.W.O.A.) is a private welfare organisation established to provide comprehensive welfare services for aged clients of all racial groups. The C.P.W.O.A. operates in the Cape Peninsula and its area has been closely defined by the magisterial districts. The area in which C.P.W.O.A. functions is bordered by Bellville, Simonstown, and Atlantis. Clients in need, who are resident outside this area, are referred to services which function in their area. C.P.W.O.A. has a Head Office in the Groote Kerk Building in Adderley Street, where some 45 staff members are based. There is an establishment of 17 qualified social workers.

The C.P.W.O.A. administers 14 Old Age Homes and Residences, which house over 1 800 aged people.

(A) - HOMES (Providing Nursing Care)

HOME	SUBURB	APPROX NUMBER OF RESIDENTS
Zerilda Steyn Memorial Home	Pinelands	372
Arcadia	Observatory	185
Sea Point Place	Sea Point	199
Lilyhaven *	Bonteheuwel	126
Erica *	Athlone	83
Nerina *	Bishop Lavis	98
Oakhaven *	Heideveld	78

* Coloured Homes

(B) - RESIDENCES (No Nursing Care Provided)

RESIDENCE	SUBURB	APPROX NUMBER OF RESIDENTS
Disa House	Gardens	239
Sheldon Park	Pinelands	85
Anchusa Court	Meadowridge	79
Muizenburg Place	Muizenburg	98
Bay Beach Place	Mouille Point	90
Sea Point Place	Sea Point	94
Pinelands Place	Pinelands	170

TABLE 16 - LIST OF HOMES AND RESIDENCES ADMINISTERED BY THE CAPE PENINSULA WELFARE ORGANISATION FOR THE AGED

The C.P.W.O.A. have a large community service with another 1 200 aged people under their care.

The focus of activities for the aged centres around the five Service Centres situated in the Cape Peninsula. Service centres are activities centres where stimulation and company can always be found. They are organised by the aged for the aged. The range of activities is large, ranging from playreading, keep-fit classes, craft classes to educational programmes. The Service centres have resources such as television, libraries and transport. Meals and refreshments are provided at a nominal cost.

SERVICE CENTRE	SUBURB	MEMBERSHIP
Disa Service Centre	Gardens	600
Muizenburg Place	Muizenburg	120
Sea Point Place	Sea Point	645
Pinelands Place	Pinelands	360
Erica *	Athlone	170

* Coloured Service Centre

TABLE 17 - SERVICE CENTRES (CLUBS FOR THE AGED) ADMINISTERED BY CAPE PENINSULA WELFARE ORGANISATION FOR THE AGED

Apart from the operation of homes, residences and service centres, the C.P.W.O.A. provides a number of community services, the most noteworthy of which are:-

4.4.1 Meals-on-Wheels

This service provides nutritious and balanced meals to aged citizens in their own homes. The meals are pre-cooked at the Service Centres, and are delivered hot by volunteer workers. Clients are categorised as either "economic" or subeconomic", the former paying R1,00 and the latter 60 cents per meal. Delivery occurs daily from Monday to Friday. Clients may purchase more than one meal at a time, a convenient arrangement for weekends. The C.P.W.O.A. works in co-operation with the Seventh Day Adventist Group who also provide a meals-on-wheels service for the aged, each group serving different areas of the Cape Peninsula.

4.4.2 Home Help Service

A team of nineteen "Home Helps" is co-ordinated by a full-time supervisor employed by C.P.W.O.A. The "Home Helps" are trained domestic workers who visit aged clients once or twice a week for a period of two to three hours. Their duties include cleaning, shopping and simple meal preparation for clients. A fee varying from 20 cents to 80 cents is charged for a two hour session. The "Home Helps" are selected by the supervisor for their suitability for working with aged and disabled clients. A short in-service training programme is designed to orientate

them to the special needs of the elderly. The demand for this service far exceeds the supply.

4.4.3 Visiting Committee

A number of volunteers perform regular calls on aged persons living alone in the Cape Peninsula. A report back system is carefully monitored by the C.P.W.O.A. Head Office.

A new project, which has recently been commenced, is a telephone service. Volunteers contact aged persons living alone on a regular basis to ensure the well-being of the client.

4.4.4 Social Work Services

A team of seventeen social workers, based at the C.P.W.O.A. Head Office, engage in case work, group work and community work throughout the Peninsula. Some 1 000 aged clients are visited regularly. It is estimated that approximately 50% of the establishment of social workers' time is spent on field work. Comprehensive files are kept for each client. A closely supervised system ensures regular calls and reports on all open cases. Food parcels, blankets and clothing are distributed to needy clients.

The C.P.W.O.A. is controlled by a Council consisting of thirty members. The Cape

Town City Council, the Divisional Council and the Department of Health and Welfare each appoint a representative to act in an advisory capacity.

4.5 The Adventist Home Care Service

The Adventist Nursing Service provide a subsidised Home Nursing Care Service to clients. They employ approximately forty Coloured and African nursing assistants. The nursing assistants are registered with the South African Nursing Council. The nursing assistants may be employed on either a full or part-time basis to provide basic nursing care to clients. The tariff is:-

R11,60 for nine hour period of duty
R 8,00 for five hour period of duty
R 5,50 for one to one and a half hour duty
R14,00 for twelve hour period of night duty

The Adventist group also run a meals-on-wheels service to the aged.

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PART THREE

CHAPTER 8

DISCUSSION OF THE FUNCTION, LIMITATIONS AND GAPS IN THE HEALTH SERVICE FOR GERIATRIC PATIENTS

A community is generally judged by the way in which it responds to the needs of the most vulnerable individuals within its population.[8] The aged should be considered as a vulnerable group as they are especially susceptible to physical and health deterioration, and to social crises, factors which are closely interrelated. For this reason, health surveillance of the aged is imperative. An organised, integrated health care service for geriatrics is orientated towards keeping the elderly in their own homes for as long as possible. The W.H.O. Expert Committee on the Planning and Organisation of Geriatric Services states the principle that geriatric services should form an integral part of the general health system, and be family and community orientated.[10]

The principle of maintaining the aged person in his own home is advantageous, in that he remains in familiar surroundings with the company of people whom he loves. However, the tempo of modern life is making it increasingly difficult for younger members of the family to care for the aged. Many families live in flats and small houses, and thus lack the accommodation to house aged members of the family. An increasing number of women are now employed, making the care of a frail elderly person difficult to maintain. The increased stress of modern living may influence the nuclear family's decision to resort to using institutional care. The increase in the number of families

with few or no children is leading to a higher proportion of old people with no children to look after them, a process that, in addition to its emotional aspects, implies the need for a contribution from the community. (5)

The increase in the number of very old people is associated with a more than appropriate increase in the use made of the health services. Provincial hospitals admit geriatric cases, but are unable to retain them as patients once the acute phases of illness are over, or if little can be done for them in hospital. The Minister of Health, in his opening address delivered at the Biennial Meeting of the South African National Council for the Aged in Cape Town in November 1976, stated:-

> "Unfortunately many urgently needed hospital beds are blocked by elderly long-stay patients who cannot be discharged because they are not able to look after themselves or have no family". (8, p408)

Frequently there is neither a place to which they may be discharged for intermediate care, or adequate domiciliary medical services to support them in their own home environment.

The appropriate use of in-patient care is of economic importance. During 1980, it was estimated that the mean cost per day per bed at Groote Schuur Hospital was R77,72. (1,p1) Occupation of a hospital bed in a convalescent or chronic care facility costs on third to half this amount. (6) Care given in long-term facilities is more appropriate to the needs of the elderly, as the emphasis would be on rehabilitation. It is thus important to transfer geriatric

patients to less expensive and more appropriate accommodation at the earliest convenience. If the aged patient is discharged home, adequate facilities for community support must be made.

The Principles of planning an effective geriatric service

The W.H.O. Expert Committee on the planning and organisation of Geriatric Services [10] outlined the following principles when planning an integrated, comprehensive geriatric health service.

* In planning geriatric programmes, the main emphasis should be on all aspects of prevention
* An holistic approach should be adopted when handling the complex medical and social needs of the aged
* The services must be orientated to the family and the community, and integration and co-ordination should be the main pattern in their development
* The spectrum of services should be wide, with different levels of care. This allows for progressive care, and the continuity of care, two essential components of a health care system for the aged
* The services should be available to all those who need them, and developed with the close participation of those using the service. [10]

The Components of an effective Geriatric Service

Phase	Action
1. Pre-retirement period	Preparation for retirement *
2. Fit and independently elderly	Continuation of fitness, productivity and occupation or interest
3. In need of some assistance	Retention in the community *
4. Relatively fit but no longer able to remain in the community	Old-aged homes
5. Minor and passing illness	Sick-bays of old-homes
6. Chronically disabled physically and/or mentally	Advanced care and varying rehabilitation *
7. Discharge from hospital	Domiciliary extension of hospital services *
8. Acute illness, injury special treatment	Hospitalisation

Direction of usual progression

Direction of effort

* Indicates area of greatest need at present

TABLE 18 - MAINTENANCE OF INDEPENDENCE : RETENTION OF THE AGED IN THE COMMUNITY (5, p326)

1. Preparation for retirement

With increasing longevity and scientific advances in methods of medical diagnosis and treatment to improve health during the later years, it is strange that the arbitrary aged of retirement should not likewise be extended. The aged should be given the option of continuing their work on a full-time or part-time basis, for as long as possible, provided they remain physically and mentally competent to do so. Extending the productive life of the elderly would make an imprint on the economy, and ensure the maintenance of a reasonable level of income which is a prerequite for wellbeing. Employment is more than gainful activity, for it also necessitates day-to-day social interaction with other people. (9)

In a survey done by Gillis and Elk (3) it was found that 20% of those retired had difficulties adjusting to retirement. They complained of a lack of occupation and purpose in life. This was more common amongst the male participants of the survey than the females, probably due to the fact that women retain their accustomed domestic role. Seventeen percent of the group interviewed stated that they had no special interests or hobbies.

Planning for the preliminary adptation for retirement should commence pre-retirement. The solution lies basically in education. The Western Province Retirement Council is aware of the need for pre-retirement counselling, and is offering pre-retirement courses.

2. Continuation of fitness, productivity and occupation or interest for the fit and independent elderly

The Cape Peninsula Welfare Organisation for the Aged (C.P.W.O.A.) with its large community service does a great deal to promote the health and wellbeing of the aged in the Cape Town area. The five Service Centres situated on the Peninsula provide invaluable activity centres for the aged. Numerous Seniors Clubs, organised by Voluntary Organisations, (e.g. S A Red Cross Society, A.C.V.V.) and Church bodies, also cater for the social needs of the aged.

3. The Retention of the Aged, who are in need of assistance, in the community

One of the most critical areas of need in Cape Town, is the support of the less fit, ageing persons, who, if they received some assistance, could remain in the community without resorting to institutional care.

Geriatric clinics, offering advice and medical screening services, are of utmost importance in keeping the elderly independent in the community. Old people frequently confuse symptoms due to illness and those which they erroneously attribute to ageing. Medical screening of the aged for preventable and correctable conditions is amongst the most worthwhile and simple of medical detention services.

The C.P.W.O.A. Service Centres provide an excellent venue for health education and health screening. The State Health Geriatric Community Health Service has commenced a Health Screening Clinic at Pinelands Place Service Centre, and have plans to extend the service to

Disa and Sea Point Service Centres. The function of the Geriatric Community Nurse is to identify health problems, and refer the patient to the appropriate resource for treatment. Invaluable time is spent counselling the client as regards the maintenance of health and the compliance of medical treatment.

The Local Authority Health Visitors also make a vital contribution to the maintenance of health for the aged. The Health Visitor visits families in the area in which she functions, giving comprehensive health care. Any aged family members are listed and encouraged to attend one of the sixteen Local Authority Geriatric Screening Clinics in the Cape Town area.

The Day Hospital Organisation also provides Geriatric facilities at the nineteen Day Hospitals in the Cape Peninsula. It seems logical that the State Health Geriatric Service, the Day Hospital Organisation and the Local Health Authority should liaise very closely in their function to prevent the overlapping of services.

Home Help services are considered the backbone of geriatric care for this group of aged in the United Kingdom. The Northumberland County Council Health Department described the Home Help Service as the most important service in prolonging independence, and relieving old age homes and hospitals.(5, 329) Difficulties such as unsteadiness, slowness, difficulty in getting dressed and moving about, or problems with managing housework, laundry, shopping, can be solved

by relatively untrained people. The C.P.W.O.A. has a home help service with nineteen staff members. An extension of this service should be considered. Health care staff must be adequately informed about the service, so that appropriate referrals can be made.

Meals-on-Wheels is a complementary service to the Home Help Services. Adequate facilities exist, but they are being under-utilised due to the public and the health care staff being unaware of the service.

There is the need in the Peninsula to develop Day Care Centres for the aged. Day Care Centres could be attached to existing Old Age Homes. This facility would cater for the frail aged who live alone, or with their families. The old person could spend the day in the company of other old people, under the supervision of the staff of the Old Age Home, thereby alleviating the family of the constant care of their aged. This arrangement would be suitable for families with both members working. The establishment of Geriatric Day Care Centres would prevent the premature admission of the aged into institutional care.

The scheme would be cost effective as facilities for night care at the Old Age Homes would not be increased.

4.) <u>Old Age Homes, with or without Nursing Care facilities</u>
5.)

Old Age Homes for the white aged appear to be adequate in the Cape Peninsula. There is an urgent need to

develop this facility for the Coloured and Black aged. The benefit of creating facilities providing nursing care is obvious, when one considers the problems of discharging the frail aged from hospital. The nursing care facilities at Old Age Homes only cater for minor and passing illnesses. A scheme by which the occupants of Old Age Residences where no nursing care is provided, may be temporarily admitted to the Sick Bay of a nearby Old Age Home, may prove beneficial. The provision of nursing care facilities is expensive, and the pooling of resources may prove to be economically viable.

6. Advanced Care and Rehabilitation for the chronically disabled Geriatric Patient

The major deficit in the provision of health care facilities for the aged in the Peninsula is the lack of interim rehabilitation for the chronically ill and disabled elderly. The function of an acute specialist hospital like Groote Schuur should be focused exclusively on the detection, diagnosis and treatment of the illness. Once the elderly patient's condition has stabilised, he should be transferred as soon as possible from the acute in-patient bed to a Geriatric Assessment Unit.

The major function of the Geriatric Assessment Unit would be to assess the extent of physical and mental disability, and resultant functional derangement caused by the illness. The patient's social environment would also be evaluated. A Geriatric Unit needs the flexibility and the facilities to separate patients into categories, as the patients generally referred to a Geriatric Unit usually consist of:-

* Those requiring intensive investigation, treatment, nursing care and rehabilitation.
* Those in the terminal stages of disease who require palliative treatment and nursing care
* Those requiring assessment and treatment for their psychological condition

General experience in the United Kingdom has shown that it is absolutely essential to keep these categories separate, as they have a disintegrative effect on each other. (5, p332) The psychogeriatric unit at Valkenberg Hospital manages the third category most effectively.

A Geriatric Assessment Unit should be sited near to Groote Schuur Hospital as most of the referrals will come from this source. It should also be in close proximity to facilities for rehabilitation and chronic care. From the Geriatric Assessment Unit, the patient might either be discharged home, referred to a rehabilitation unit or transferred to long-term convalescent care.

The Geriatric Assessment Unit would fall under the overall guidance of the Professor of Geriatrics at the University of Cape Town, who holds a triparite post. Apart from providing comprehensive care to this vulnerable group of the population, the Geriatric Unit would have the advantages of providing a centre for teaching and research into the special problems of the sick aged.

The facilities for the care of the chronically ill patients are limited in the Cape Peninsula. Conradie Hospital is the only institution in this region

catering for this group of patient. Eaton, G. F. Jooste, Goodwood and Booth Memorial Hospitals all provide limited facilities for convalescing patients. Long waiting lists at these institutions prevent the efficient transfer of patients from the acute Provincial Hospitals. Care in these institutions is more orientated to custodial care than to dynamic rehabilitation. The types of geriatric patients who would benefit from a period of intensive rehabilitation would be selected patients suffering from strokes, parkinsonism, arthritis, amputations and hip fractures. At present these patients are either being discharged home prematurely, without adequate domiciliary support, or retained at unnecessary expense in the acute inpatient facilities. The patients who appear to be most severely neglected are those suffering from strokes. The majority of these patients are admitted to the Emergency Medical Units at Groote Schuur. Due to the chronic nature of their illness, the transfer of patients with cerebrovascular accidents to the medical wards of Groote Schuur Hospital is unsuitable. They cannot be retained in the Emergency Medical Units, and are consequently discharged home. The District Nursing staff lack the facilities to cope with these patients on district, and complain of the difficulties involved in trying to support a reluctant and apprehensive family on district, cope with a comatosed patient requiring nasogastric feeding and catheter care.

7. <u>Domiciliary extension of hospital services for Geriatric Patients discharged from Hospital</u>

Domiciliary care for geriatric patients discharged from hospital is provided by numerous services, but

remains fragmented and unco-ordinated. State Health employs two experienced Geriatric Community Health nurses whose sole function is to promote the care of the aged in the community. The District Nursing Service, employed by the Day Hospitals Organisation, deals with patients requiring the services of a registered nurse on district. Seventy-five percent of all the referrals for domiciliary care coming from Groote Schuur Hospital are to the District Nursing Service. The Health Visitors from Local Authority provide a family orientated preventive and promotive health care service. Voluntary Organisations provide nursing assistants to perform basic nursing care functions for patients requiring nursing care in the community. The National Cancer Association has two Community Health nurses who are able to cope with the special problems of nursing terminally ill oncology patients in their own homes. The particular orientation of each domiciliary service leads to confusion and overlapping of services. Some patients may have contact with as many as three or four agencies, whilst others do not receive the domiciliary nursing care which they need. The diversification of services is not in the interest of the patient. A lack of communication between the different agencies frequently leads to confusion as to what advice and nursing care is being given.

Two of the facilities being offered in the community urgently need to be extended. The District Nursing Service is severely understaffed for the workload which they carry. There is also an urgent need to extend the Home Nursing Service of the Voluntary Organisations. One of the greatest needs in the

community is for a subsidised Home Nursing Service. This service could be staffed by trained Nursing Assistants under the supervision of registered nurses. Thirty-six percent of the patients being discharged from Groote Schuur need assistance with activities such as bathing, dressing and becoming ambulant. The State Health Geriatric Nursing Service has two vacant Community Health nurses' posts, which will be filled in the near future.

The problem posed is; how can the various domiciliary nursing services co-ordinate and integrate their functions so that the elderly have access to a system of total and continuing health care?

Firstly, communication must be improved between the different services. The Regional Organiser of State Health in the Western Cape has seen this need, and a quarterly meeting of all services concerned with the domiciliary care of the aged has been proposed. The first meeting was during March of 1982, and was attended by staff of State Health, the Day Hospitals Organisation, Local Authority, and the Voluntary Organisations. Staff members attending consisted mainly of nurses and social workers concerned with the care of the aged. The objective of these quarterly meetings is to discuss problems and policies in caring for the aged in the community. The community liaison nurse from Groote Schuur Hospital would be a valuable participant at these meetings.

Communication may further be fostered by routine meetings of the domiciliary nursing staff of the

different zones in the Cape Town area. The State Health Geriatric Community Health nurse should be included in these meetings, in the area in which she functions. The objective of these routine meetings would be to integrate services, and discuss patients who present problems regarding their care in the community. By meeting face-to-face, intermittent communication regarding mutual patient care may be encouraged. Patients who are visited in their own homes, should possess a Nursing Care Card in a large durable envelope. Each member of the domiciliary health team may record her visit, and subsequent treatment and evaluation on this card. This would lessen the confusion as to overlapping of services which exists at present when more than one member of the domiciliary health team visits a patient.

The State Health Geriatric nurse is the person most suitable to act as team leader, and co-ordinator of services when dealing with geriatric patients in the community. It is thus recommended that all geriatric patients with nursing care problems on discharge, be referred directly to her. The Geriatric Community nurse would then be able to visit the patient and his family, assess their situation and co-ordinate facilities for their care. The State Health Geriatric nurse is able to follow up the care of the patient in the community, and therefore intercept crises by effective management. Specialists in the nursing care of oncology patients, psychiatry, stoma care and stroke patients may be consulted in order that they may contribute their advice as regards the better management of the patient in the community.

There is a need to extend the Home Nursing Service presently being provided by the Voluntary Organisations. Affluent patients do not have a problem as they are able to utilise one of the numerous private Nursing Agencies in the Cape Peninsula. However, many of the patients in need of home nursing do not have the resources to pay for the service. The St John's Ambulance Home Nursing Service is free, but limited. The Red Cross Society's Home Nursing Service charges the nominal fee of R6,50 per day, and provides a twelve day free service for indigent patients. Unfortunately both these services are insufficient to cater for the need which exists. The extension of the home nursing service is vitally important if the chronically disabled patients are to be retained in the community. Perhaps the most efficient way of fulfilling this need would be for the Day Hospitals Organisation to employ Nursing Assistants to work in conjunction with the District Nurses in the community. While the District Nurses are performing the more technical nursing tasks for patients in their zone, the Nursing Assistants could be assisting the families cope with the basic nursing care requirements of their patients. The Nursing Assistant would be under the guidance of a registered nurse. This scheme may prove to be the most cost-effective of solving this problem.

8. <u>Hospitalisation of the Aged for the treatment of acute illness, injury or for special treatment</u>

Geriatric patients in the Cape Peninsula have ready access to among the most advanced and sophisticated

curative medicine in South Africa.

Recommendations to improve the co-ordination and integration of Health Services for the aged

At attempt has been made to determine how the health needs of the elderly are met in the present health care system with State, Provinical Administration and Local Authority each having a respective function. A great deal has been said about the fragmentation and overlapping of services which result from this triparite system. The present legislation does not permit a change in the system, but the following recommendations might lead to increased co-ordination and integration of services, thereby giving the elderly greater access to a system of total and continuing health care.

1. State Health, the Day Hospitals Organisation and the Local Authorities, each of whom is providing a geriatric screening service, liaise closely in an attempt to combine their efforts in the preventive aspects of Geriatric Health care.

2. The Cape Peninsula Welfare Organisation for the Aged investigates the possibility of publicising and extending their Home Help Service.

3. The Cape Peninsula Welfare Organisation for the Aged investigates the possibility of establishing Day Care Centres at existing Old Age Homes for the care of frail, aged clients who live in the community.

4. The C.P.W.O.A. investigates the possibility of Old Age Residences which provide no nursing care facilities sharing the Sick Bay facilities of the Old Age Homes.

5. The Cape Provincial Administration investigates the possibility of establishing a Geriatric Assessment Unit, with approximately ten beds, for the assessment and treatment of geriatric patients. The Geriatric Assessment Unit should be in close proximity to a facility catering for rehabilitation and the chronically ill. It must also be sited near to Groote Schuur Hospital from where the majority of referrals will come.

6. The Cape Provinical Administration investigates the possibility of establishing a short-term rehabilitation unit catering for patients suffering from disabling, degenerative diseases.

7. Further research into the care of patients suffering from cerebrovascular accidents should be conducted.

8. Communication at all levels of management between the State Health, Provincial Administration and Local Authority domiciliary nursing care services should be initiated and promoted. The objective of this communication would be to encourage the integration of services for the aged.

9. A uniform Nursing Record Card be issued to any patient seen on district. Any member of the health team visiting this patient should be encouraged to report on his visit. This would lead to increased communication between the services, and better continuity of care.

10. All geriatric patients who present aftercare problems on discharge from hospital be referred via the Community Liaison nurse to the State Health Geriatric nurse, who would assume the role of team leader in the nursing care of geriatric patients.

11. The Cape Provincial Administration investigate the possibility of increasing the District Nursing Service.

12. A Home Nursing Service, consisting of Nursing Assistants, be established in affiliation with the District Nursing Service.

13. The Community Health staff use the nursing staff with special skills in stoma care, psychiatry, oncology and rehabilitation to contribute to the care of patients in need of these skills in the community.

14. That the Voluntary Organisation promoting the establishment of the Hospice for the Terminally ill patient be encouraged and supported. The Hospice would serve as an invaluable resource in handling the special problems of the terminally ill patient.

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PART FOUR

CHAPTER 9

COMMUNITY LIAISON AT GROOTE SCHUUR HOSPITAL

THE ESTABLISHMENT OF A DEPARTMENT OF COMMUNITY LIAISON AT GROOTE SCHUUR HOSPITAL

The historical evolvement of the health organisation in South Africa has resulted in a complex and fragmented health system. Providers of health care function in isolation to one another, although geographically they may be in close proximity. The lack of an adequate system of co-ordindation frequently results in poor transferral of information from one service to another. This gap is particularly evident between the curative and community services.

The Provincial Administration is responsible for the curative health services in South Africa. Nursing education falls under the jurisdiction of the Provincial Administration. Student nurses have a heavy service component to their training, and it is therefore only logical that their experience will be predominantly in episodic, institutionalised, curative medicine. The South African Nursing Council has attempted to remedy this imbalance by insisting that each student completes a minimum of 120 theoretical and 160 practical hours in Community Health before professional registration. However, few student nurses on completion of their education, have imbibed the philosophy underlying Community Health, or become familiar with the complex network of health facilities which are available in the community. Due to the shortage of nursing staff, nurses work under heavy pressure in the hospital situation. This pressure, combined with a lack of awareness of patients' difficulties and needs on discharge, leads to the assumption

that their responsibility regarding patient care ends once the patient is discharged from their ward.

The appointment of a community liaison nurse is a relatively new concept which has evolved from the need to bridge the gap that exists between hospital and home to ensure effective continuity of care. Muriel Skeet [4] during 1970, was the first to highlight the advantages of having a nurse specialist in community liaison. This need was recognised at Groote Schuur Hospital, and a Community Liaison nurse, who was an experienced Community Health nurse, was appointed on 1 August 1981.

The Role of the Community Liaison Nurse

The Community Liaison nurse forms part of the health team. She receives referrals from the ward staff if they have problems regarding the aftercare of a patient which they find difficult to solve. The referral is usually verbal and informal. The Community Liaison nurse is regarded as the link between the hospital personnel, the Community Health staff, the patient, and the patient's family and friends. She is able to respond to the queries regarding the patient's continuity of care. This has greatly assisted the Community Health staff, and families, who have experienced difficulties in the past in obtaining additional information regarding the patient's care.

A person appointed to the role of Community Liaison nurse must be skilled in several spheres. Firstly, an in-depth clinical knowledge is essential. Secondly, she must be familiar with the principles of community health, and the network of community facilities which exist. Thirdly, she must be skilled at interviewing the patient and his family,

and fourthly, she should be an effective educator able to conduct inservice training courses. Teaching skills are essential at the one-to-one basis, as well as in group education, as the Community Liaison nurse is responsible for educating both the patient, his family, and guiding nursing staff with the many facets of aftercare planning. Finally, the Community Liaison nurse is in an excellent position to conduct research into methods of improving the continuity and quality of nursing care.

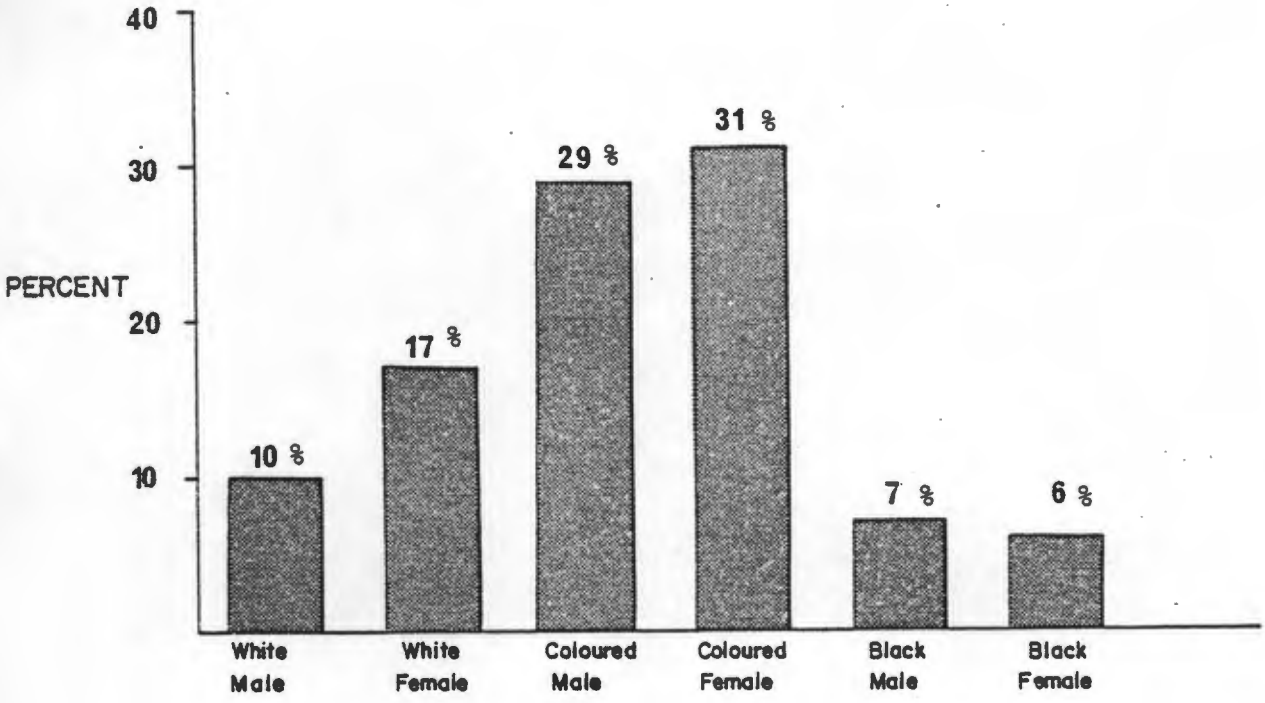
An Analysis of the Referrals to the Department of Community Liaison

1. Number of Referrals

During the period from 1 August to 31 December 1981, 808 patients were referred through the Department of Community Liaison at Groote Schuur Hospital. Twenty-eight of the patients referred died unexpectedly whilst still receiving care in the hospital. The Community Liaison nurse was thus responsible for making the aftercare arrangements for 780 patients during a five month period.

On commencement of her activities, the Community Liaison nurse in conjunction with the researcher, designed a referral form similar to that in use at the Royal Marsden Hospital, London. (Appendix 5) The data from these forms was coded, and then analysed on the UNIVAC 1100/81 computer at the Computing Service of the University of Cape Town. The analyses were performed using the PID, P5D and P3F programmes of the April 1977 University of Wisconsin version of the BMPD statistical package. (2)

2. Race and Sex Distribution



RACE / SEX DISTRIBUTION

FIGURE 8 RACE / SEX DISTRIBUTION OF PATIENTS REFERRED TO DEPARTMENT OF COMMUNITY LIASON.

Asiatic patients are classified as Coloured when admitted to Groote Schuur Hospital. Seventy-three percent of the patients referred to the Department of Community Liaison were from the non-white section of the Hospital.

3. Age Distribution

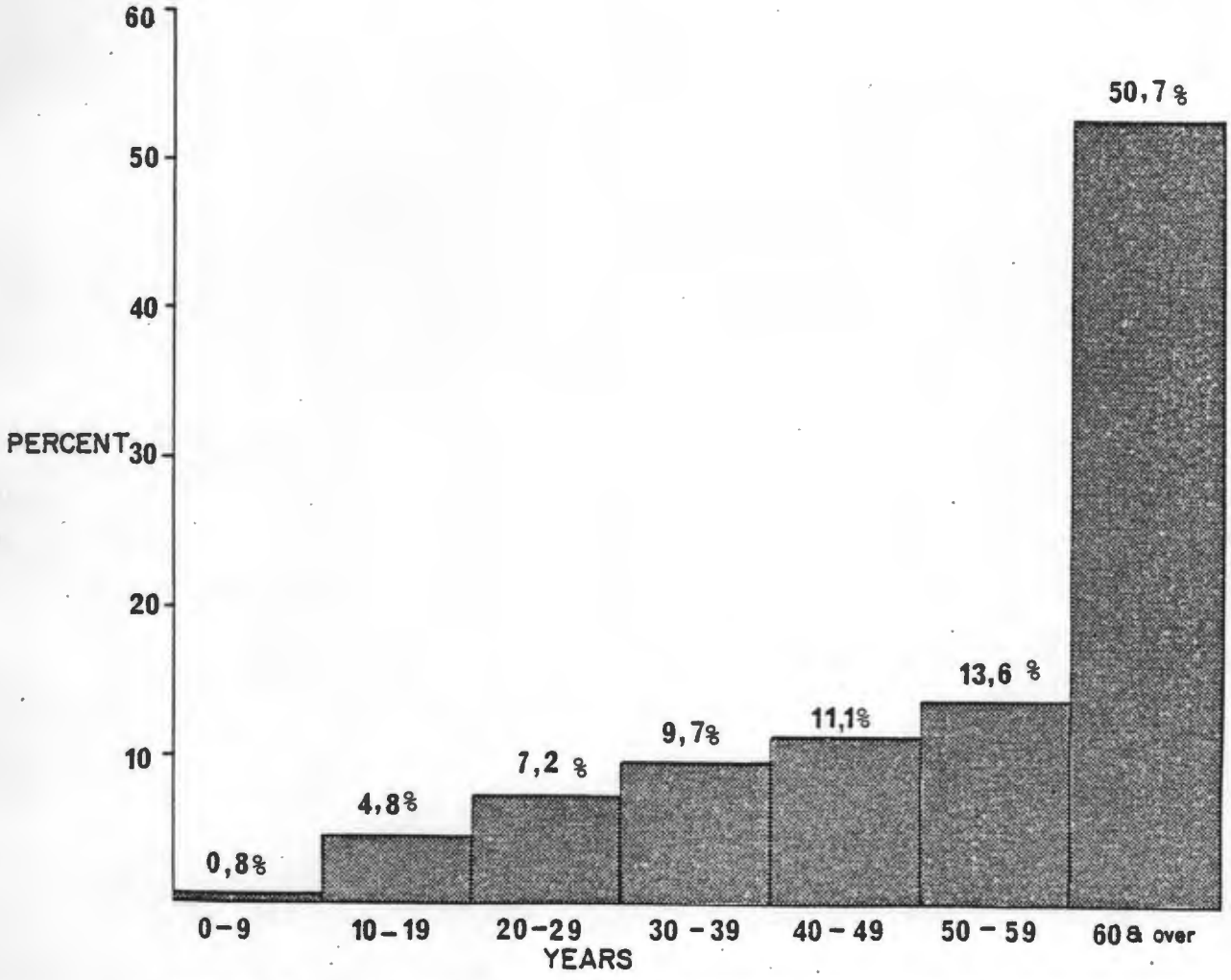


FIGURE 9 AGE DISTRIBUTION OF PATIENTS REFERRED TO THE DEPARTMENT OF COMMUNITY LIASON.

Fifty-three percent of the patients referred to the Department of Community Liaison were 60 years of age or older. The low percentage of paediatric patients can be explained in that a specialist paediatric hospital, Red Cross, Hospital, is in close proximity to Groote Schuur Hospital. Groote Schuur thus has limited facilities for very young patients.

4. Race/Sex Distribution of patients over the age of 60 years referred to the Department of Community Liaison

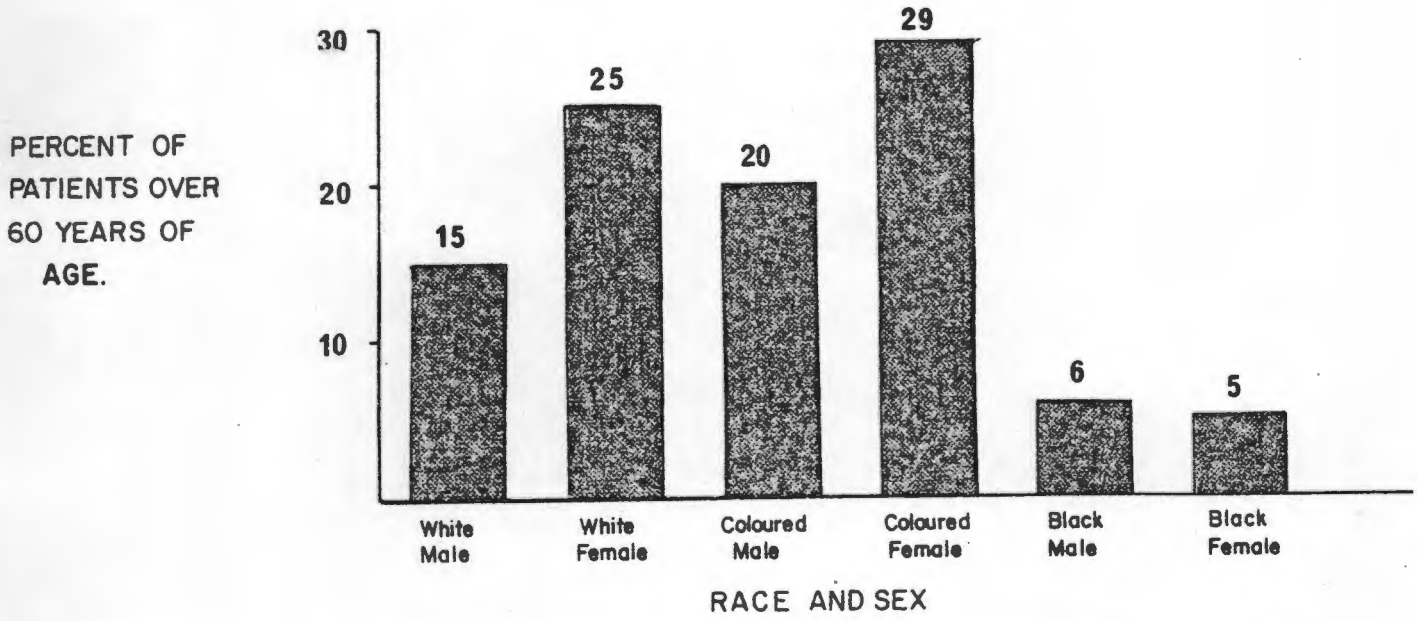


FIGURE 10. RACE/SEX DISTRIBUTION OF PATIENTS OVER THE AGE OF 60 YEARS REFERRED TO THE DEPARTMENT OF COMMUNITY LIASON.

Female patients over the age of 60 years were more predominant than male patients. This is due to the greater life expectancy of the female.

5. Units refering patients to the Department of Community Liaison

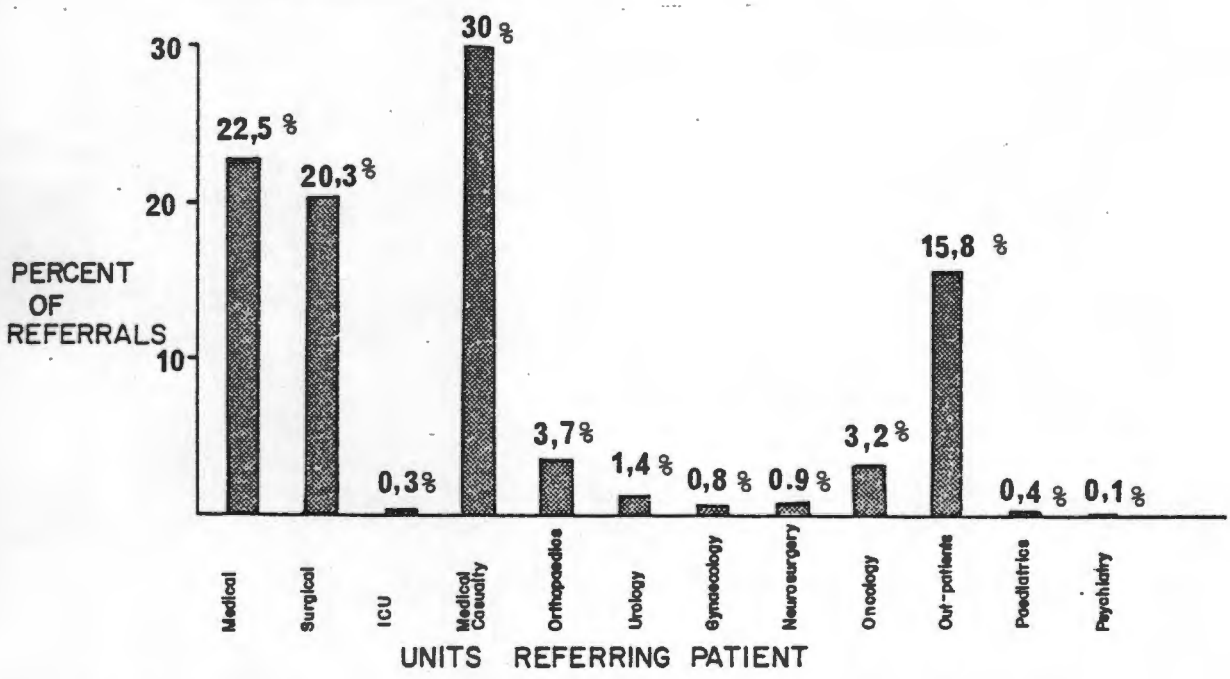


FIGURE II. UNITS REFERRING PATIENTS TO THE DEPARTMENT OF COMMUNITY LIASON.

The majority of patients to the Department of Community Liaison were treated in Medical Casualty. This is an acute medical emergency unit designed for patients who require short-term treatment. The patient seldom occupies a bed for longer than 48 hours in this unit before either being discharged home, or transferred to the medical wards of the hospital. The majority of patients who are admitted to this unit are elderly and chronically ill. The health team in Medical Casualty is able to give them the acute care which the require to stabilise their condition. Unfortunately, due to the pressure of patient load, the health team is unable either to investigate or attempt to rectify the social circumstances which could have led to the deterioration in the patent's condition. Bed

occupancy during 1980 was calculated to be 150% in G1 (white Medical Casualty) and 221% in G2 (Coloured Medical Casualty). (1, pp133-134) It is obvious that there is a great need for a Community Liaison nurse in this unit. The medical staff are fully aware of this need, and have attempted to utilise the Community Liaison nurse to the optimum.

Apart from the Medical and Surgical wards of Groote Schuur Hospital, it is the Out-patients Department who made most use of the Community Liaison Department. Most patients discharged from Groote Schuur Hospital are given a follow-up appointment for Out-patients Department. A Community Liaison nurse is able to advise mmembers of the health team as to the most appropriate resources in the community which can continue caring for the patient. It is frequently neither efficient nor cost-effective for the patient to keep returning to Groote Schuur Out-patients Department, when the Day Hospitals Organisation or the patient's own general practitioner could continue his treatment. Attendance at Groote Schuur Out-patients Department may be prolonged by the patient seeing a junior medical officer who is not familiar with the patient's case history, and subsequently insecure about discharging or transferring the patient. From the patient's point of view, continual Out-patients attendance is expensive, time consuming and exhausting.

6. Diagnoses of Patients referred to the Department of Community Liaison

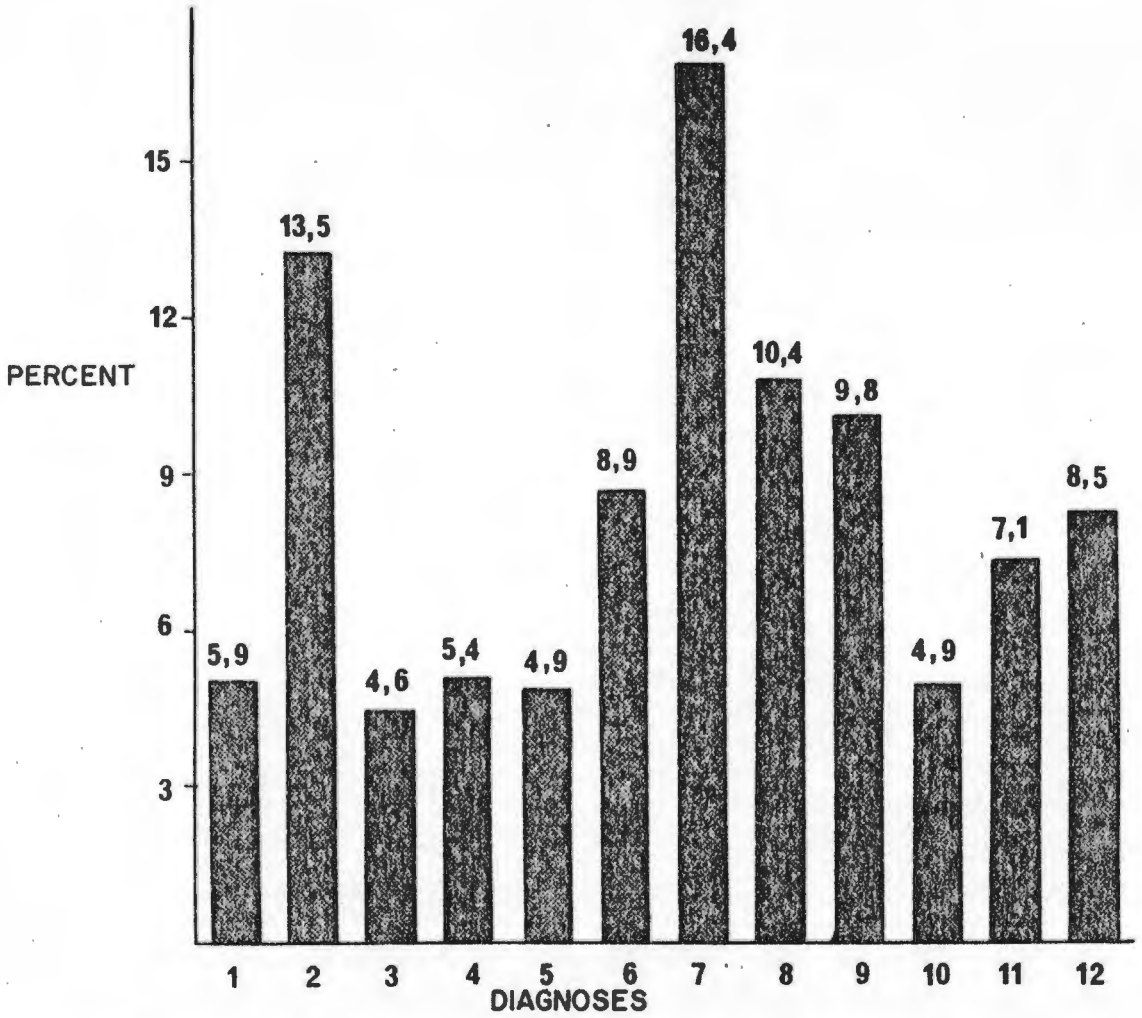


FIGURE 12. THE MOST FREQUENT DIAGNOSES OF PATIENTS REFERRED TO THE DEPARTMENT OF COMMUNITY LIASON.

LEGEND

1. Tuberculosis
2. Endocrine and Metabolic Diseases
3. Diseases of the Nervous System
4. Hypertensive Disease
5. Ischaemic Heart Disease
6. Diseases of the Pulmonary Circulation
7. Cerebrovascular Disease
8. Other forms of Circulatory Disease
9. Diseases of the Digestive System
10. Diseases of the Urinary System
11. Diseases of the Musculo-Skeletal System
12. Fractures

Diagnoses were coded by using the World Health Organisation "International Classification of Diseases" (9th edition).[5] Many of the patients, most frequently patients over the age of 60 years, suffered from multiple pathologies. Diabetes Mellitus was the most frequent pathology categorised under Endocrine and Metabolic Diseases. Diseases related to pathology of the cardiovascular system were by far the most frequent. (Categories 4-8 on Figure 12). 16.4% of all patients referred to the Department of Community Liaison were disabled by cerebrovascular accidents. (Category 7 on Figure 12).

7. Treatment required on Discharge

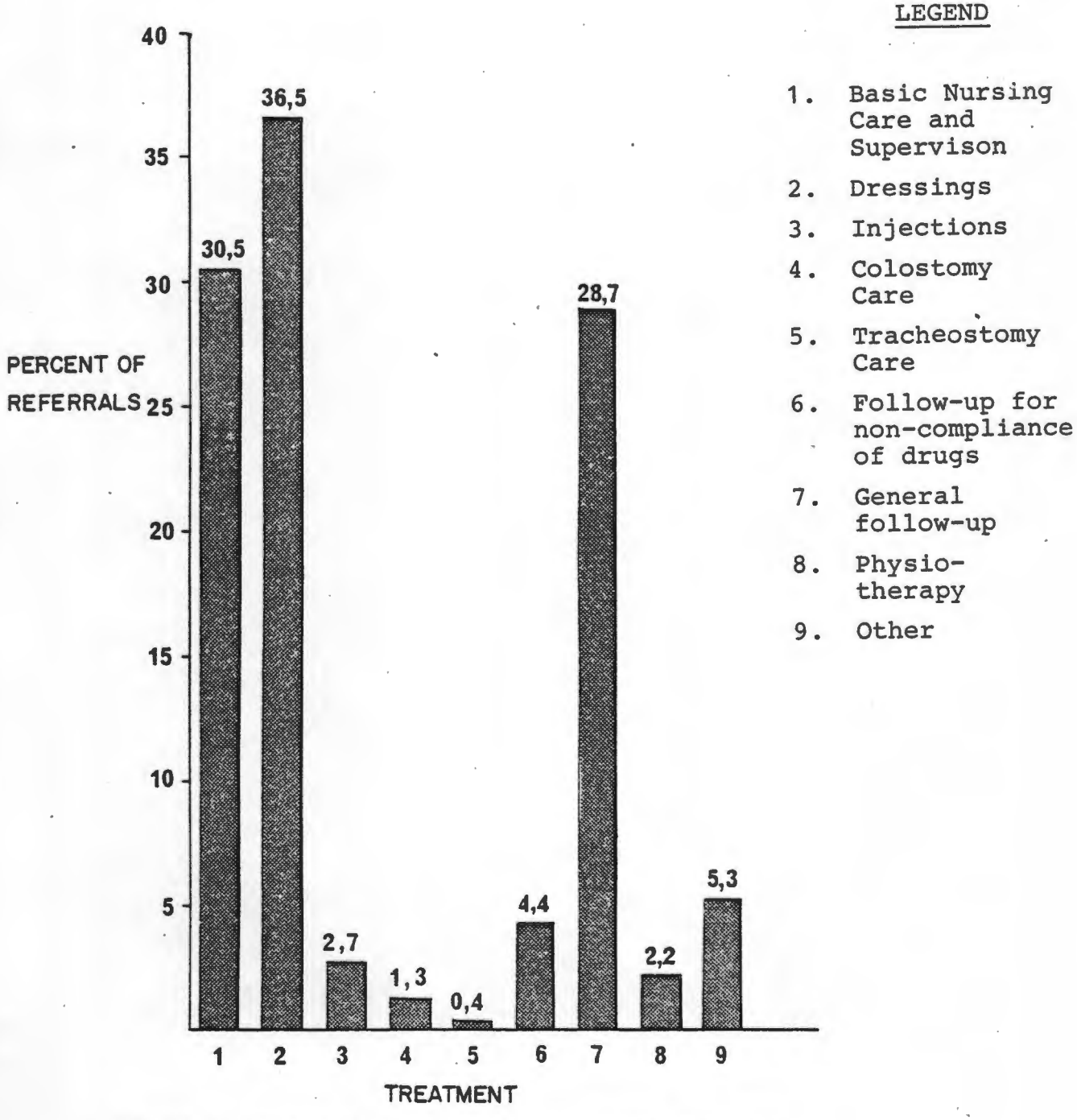


FIGURE 13. TREATMENT PATIENT REQUIRED ON DISCHARGE

Several patients were referred for more than one treatment, e.g. dressings and injections. The most frequent requests for care made to the Community Health staff were for dressings (36,5%), basic nursing

care and supervision (30.5%) and general follow-up of a patient (28.7%), for patients being discharged from Groote Schuur Hospital.

The most frequent treatment requested in the category of "other" was the erection of traction at home for patients suffering from back and orthopaedic problems.

8. Community Service utilised

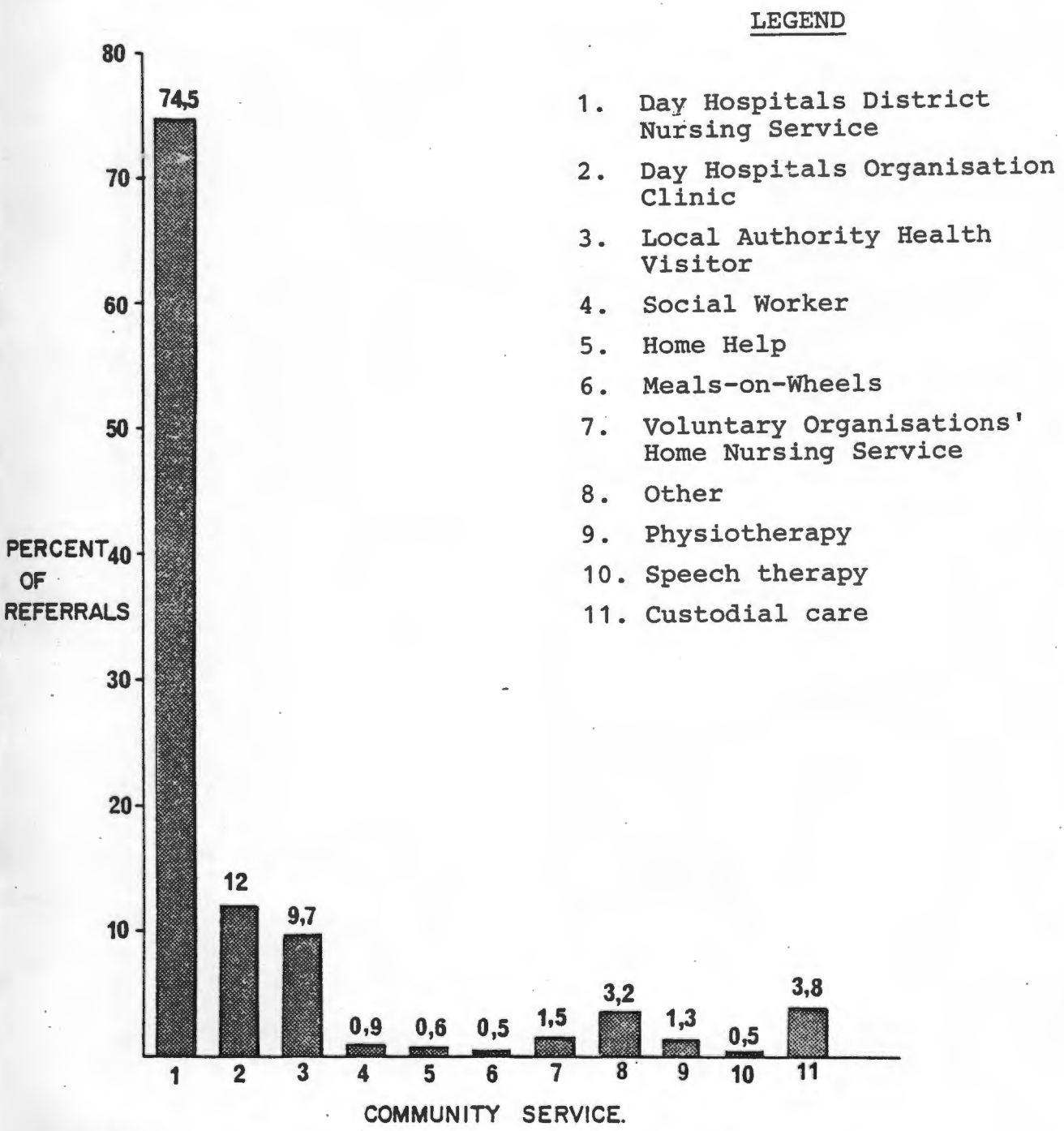


FIGURE 14 COMMUNITY SERVICES UTILISED BY THE DEPARTMENT OF COMMUNITY LIASON AT G.S.H.

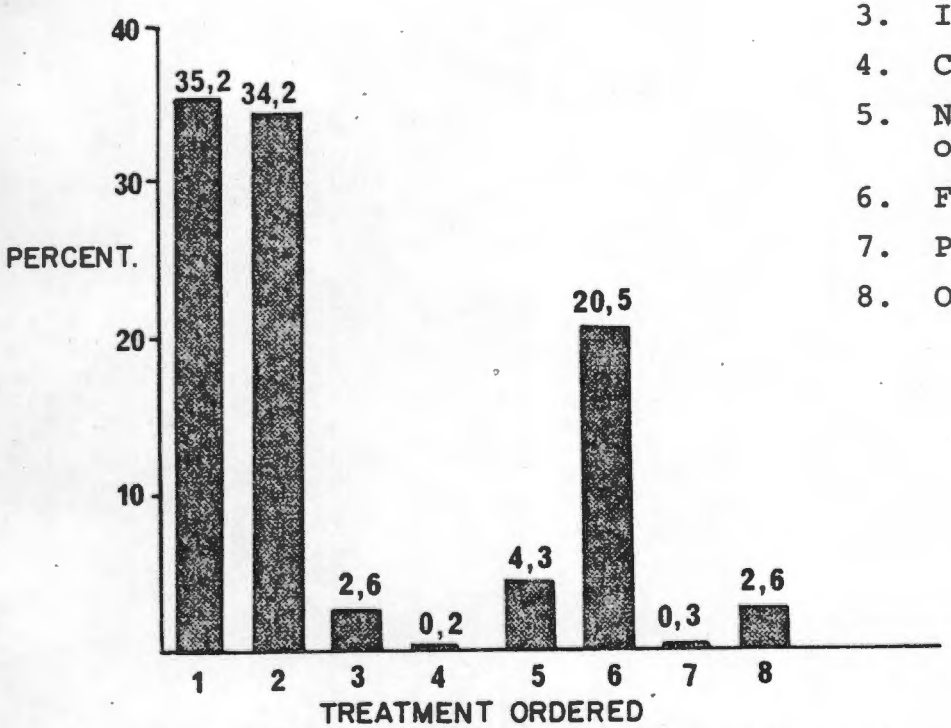
Patients were frequently referred to more than one community service, e.g. District Nurse and Home

Help Service. Most of the patients discharged from Groote Schuur Hospital who were referred to the Department of Community Liaison for aftercare, were referred to the Day Hospitals District Nursing Service. The establishment of this vital service consists of twenty-five district nursing sisters. They therefore carry a considerable individual work-load. Only 12% of the patients were referred for continuing care to the Day Hospitals Organisation clinics. None of the 780 patients were referred to an Occupational Therapist on discharge. This was probably due to the paucity of Occupational Therapy posts at the Day Hospitals Organisation. This is regrettable as a high percentage of the patients suffered from disabling diseases.

Less than 10% of the patients were referred to the Health Visitor employed by Local Authorities. The Health Visitor has an important role to play in linking services, and ensuring continuing support, when required, after active nursing care has ceased. She thus has a prominent role to play in the care of a patient with chronic illness following discharge from hospital.

Surprisingly few patients were referred to the Voluntary Organisations for assistance with after-care. The home nursing facilities supplied by these Voluntary Organisations are limited, and they have inadequate resources to cope with the needs of patients being discharged from Groote Schuur Hospital.

9. Primary reason for referral to the Day Hospital District Nursing Service

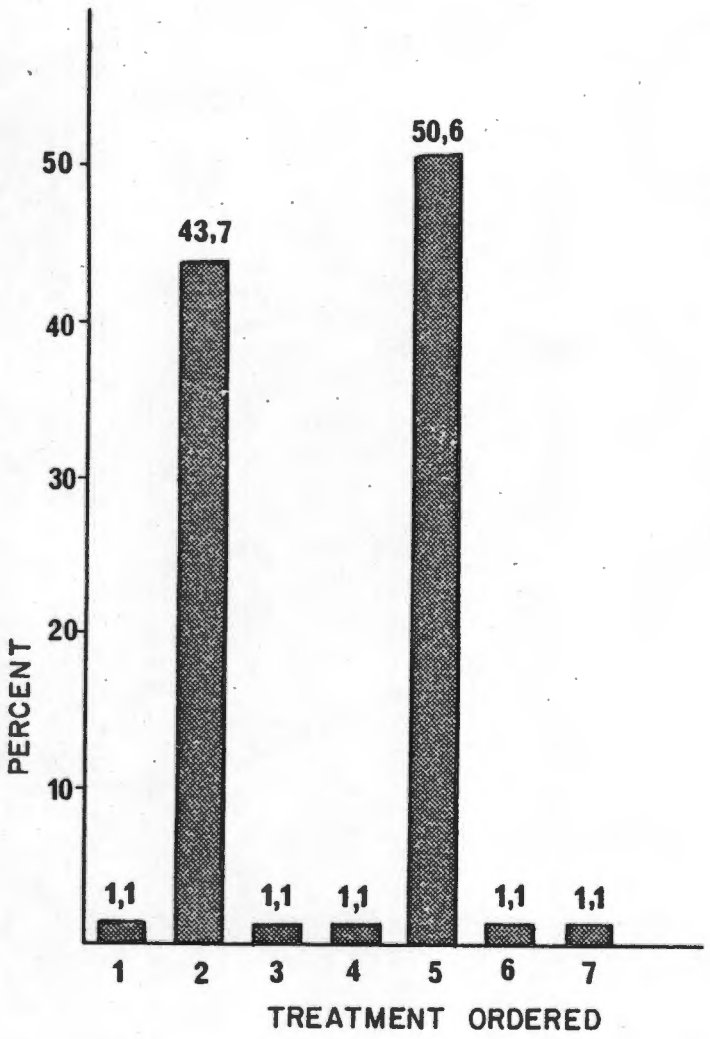


LEGEND

1. Basic Nursing Care and Supervision
2. Dressings
3. Injections
4. Colostomy care
5. Non-compliance of drugs
6. Follow-up
7. Physiotherapy
8. Other

FIGURE 15. PRIMARY REASON FOR REFERRAL TO THE DAY HOSPITAL DISTRICT NURSING SERVICE.

10. Primary reason for referral to the Day Hospital Organisation Clinics



LEGEND

1. Basic Nursing Care
2. Dressings
3. Injections
4. Follow-up for non-compliance of drugs
5. General follow-up
6. Physiotherapy
7. Other

FIGURE 16. PRIMARY REASON FOR REFERRAL TO THE DAY HOSPITAL ORGANIZATION CLINIC.

11. Primary reason for referral to the Local Authority Health Visitor

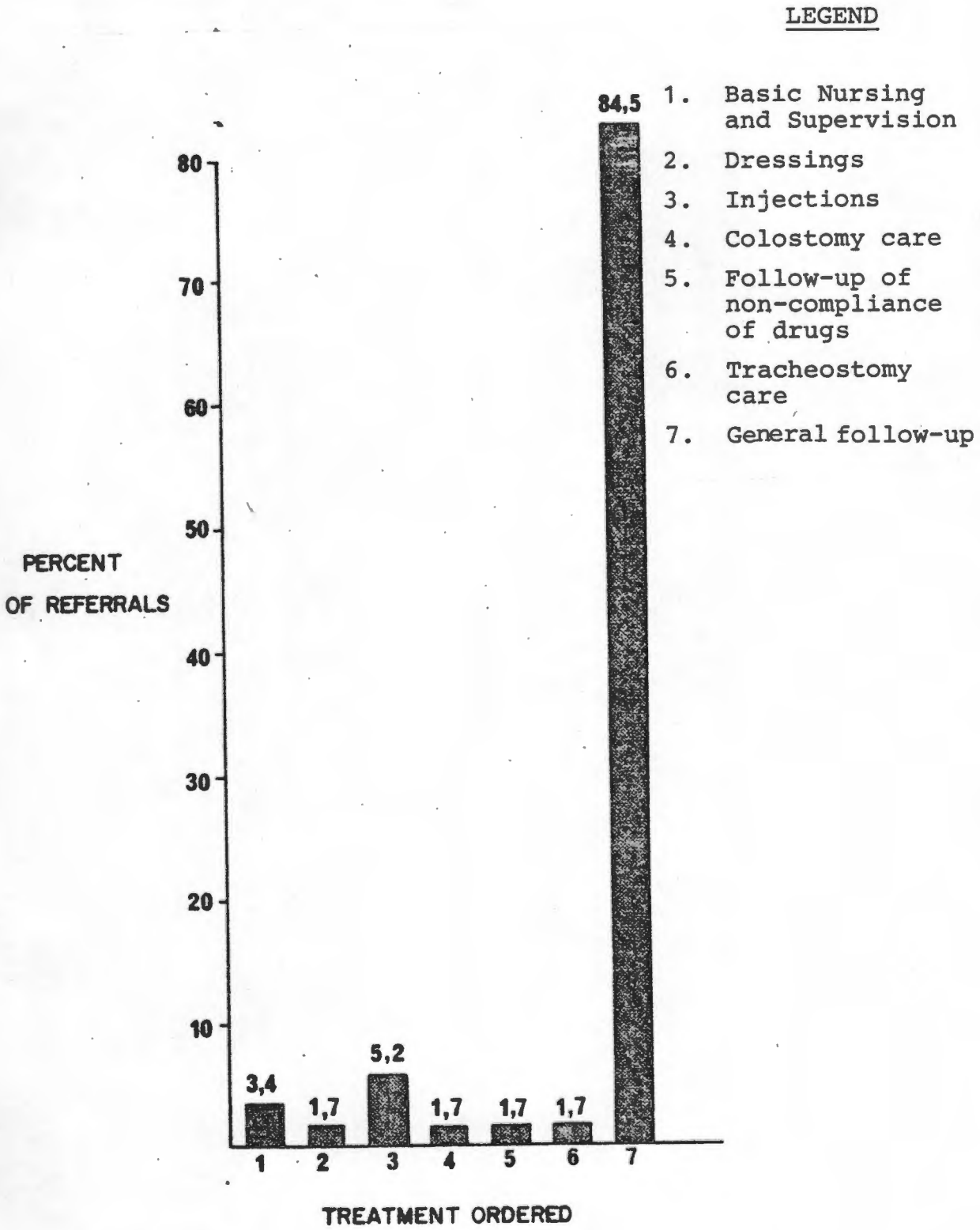
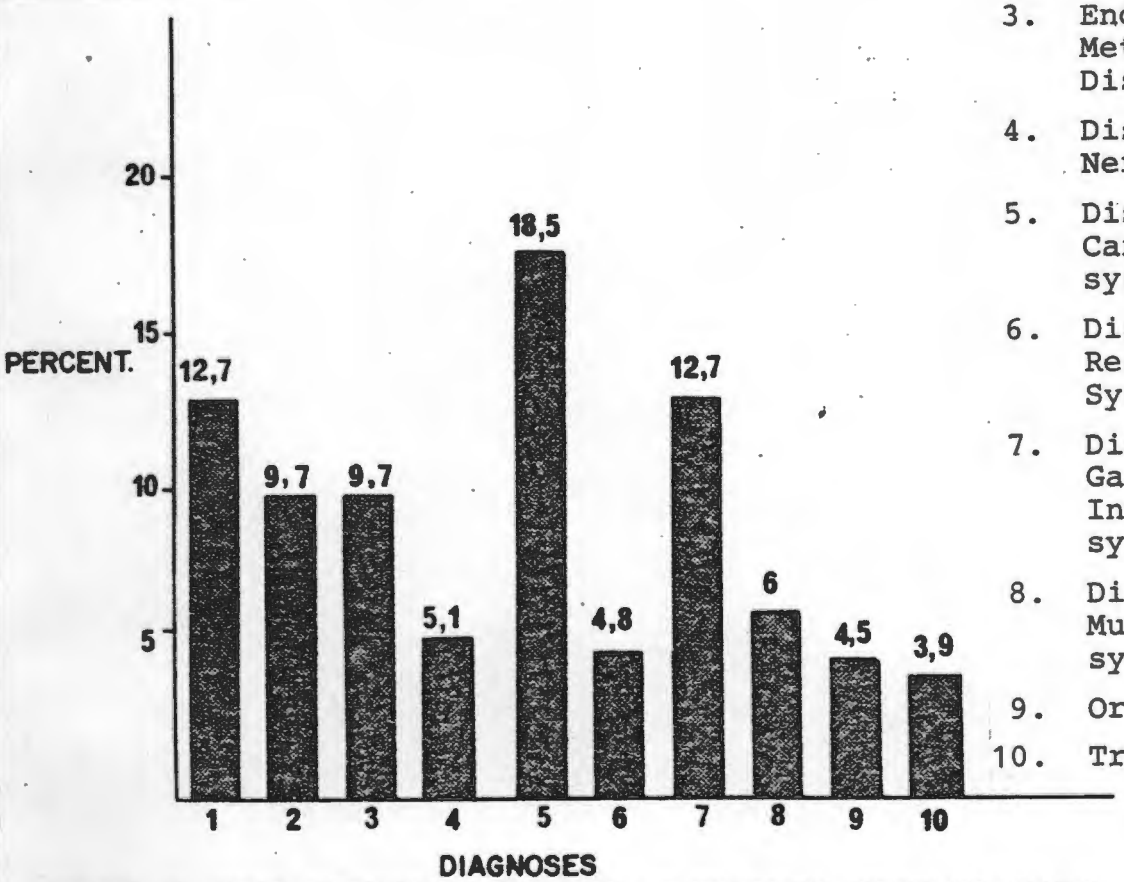


FIGURE 17. PRIMARY REASON FOR REFERRAL TO THE LOCAL AUTHORITY HEALTH VISITOR

12. Diagnoses and Age

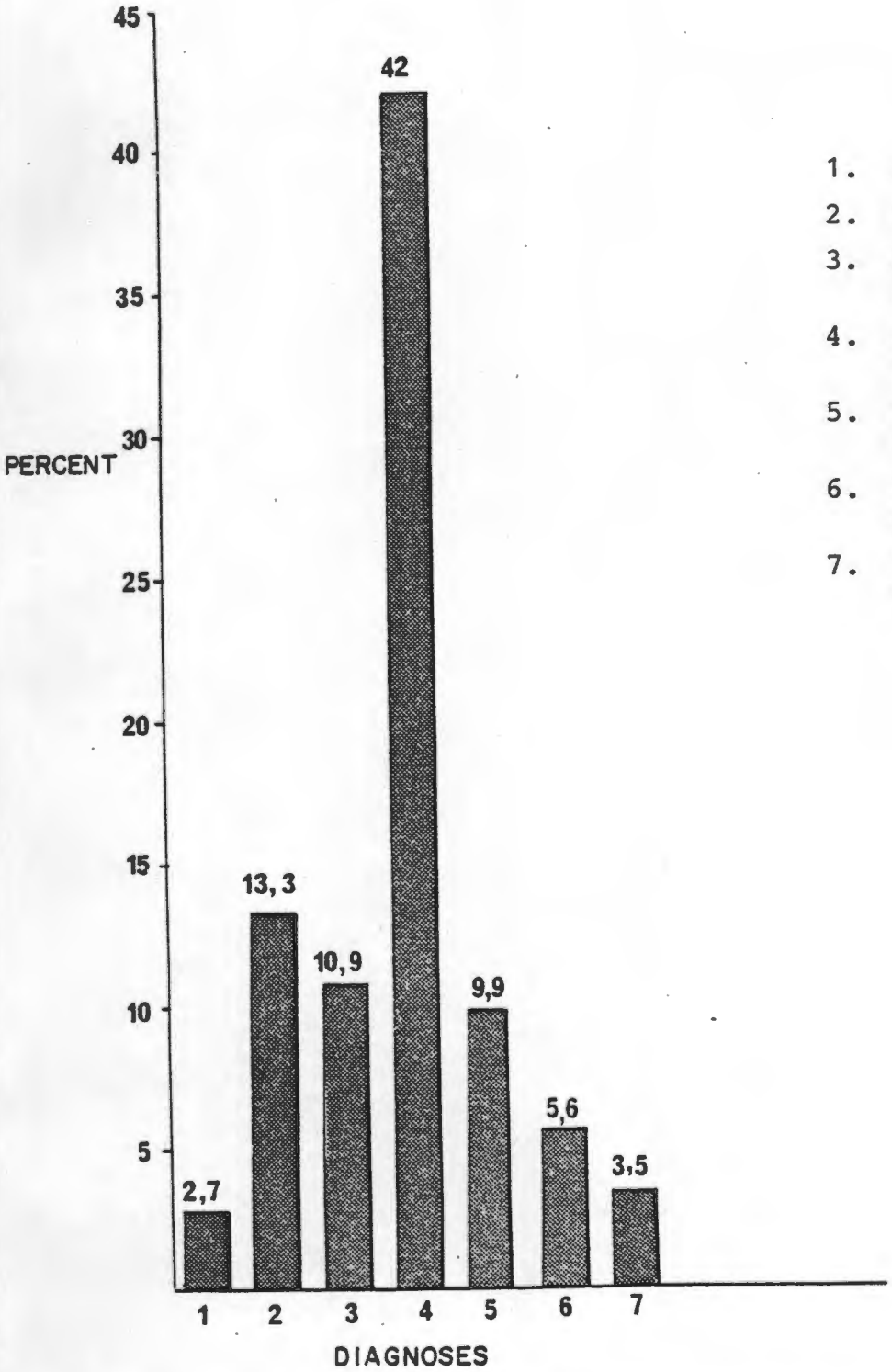
53% of the patients referred to the Department of Community Liaison were 60 years of age or older. The more aged patients tend to be affected by multiple pathologies which are chronic and lead to increasing disablement. This became evident when an analysis was made of the diagnoses of the patients below and above the age of 60 years.



LEGEND

1. Infective diseases
2. Carcinoma
3. Endrorine & Metabolic Diseases
4. Diseases of the Nervous System
5. Diseases of the Cardiovascular system
6. Diseases of the Respiratory System
7. Diseases of Gastro-Intestinal system
8. Diseases of Musculo-Skeletal system
9. Orthopaedics
10. Trauma

FIGURE 18. MOST FREQUENT DIAGNOSES OF PATIENTS UNDER 60 YEARS OF AGE WHO WERE REFERRED TO THE DEPARTMENT OF COMMUNITY LIASON.



LEGEND

1. Infective Diseases
2. Carcenoma
3. Endocrine & Metablic Diseases
4. Diseases of Cardio-vascular System
5. Disease of Respiratory System
6. Diseases of Gastro-Intestinal System
7. Diseases of Gastro-Urinary System

FIGURE 19 MOST FREQUENT DIAGNOSES OF PATIENTS OF 60 YEARS OF AGE & OVER – WHO WERE REFERRED TO THE DEPARTMENT OF COMMUNITY LIASON.

Discussion

Seventy-three percent of the patients referred to the Department of Community Liaison for continuing care came from the non-white section of the hospital, and twenty-seven percent from the white section. Fifty-three percent of the referrals were for patients over the age of sixty, indicating that the need for aftercare is frequently greater for the older patient. Of these, 59% were female and 41% were male. The predominance of elderly female patients is attributable to the longer life expectancy of the female.

It should be noted that Medical Casualty referred 30% of the patients in the survey. Medical units referred 22.5%, while surgical units were responsible for 20.3% of the referrals. The other area which utilised the Department of Community Liaison extensively was the Out-patients Department (15.8%). The Oncology Department was responsible for only 3.2% of the referrals. This comparatively low figure is probably due to this Department having its own system of dealing with the problems of continuity of care. The two social workers who form part of the Oncology Unit health team are responsible for making aftercare arrangements. They tend to liaise closely with the National Cancer Association which has a home nursing service. Although the referral rate from the Oncology Department was surprisingly low, 22% of the patients referred to the Department of Community Liaison had malignant diseases. The initial survey of discharged patients indicated the vulnerability of these patients and the need for domiciliary nursing care and support. It is probable that these patients are discharged from the general medical and surgical departments of the hospital.

Forty-seven percent of the patients referred to the Department of Community Liaison had some form of cardiovascular pathology, which is indicative of the predominance of this type of disability. Sixteen percent of these patients were disabled by a cerebrovascular accident. Most of this group of patients were admitted to Medical Casualty for a maximum period of 48 hours before discharge to their families for home nursing. The family frequently feels intensively apprehensive about caring for such severely disabled relatives, especially if their care includes nasogastric feeding and an indwelling catheter. The community facilities are entirely inadequate to assist families with this difficult task. The facilities for the chronically ill patients at Conradie, G. F. Jooste, Eaton and Booth Memorial Hospital are unable to provide interim care. (3, pp4-7) As stroke patients require a progressive programme of rehabilitation, the need for a Stroke Unit with a comprehensive approach to patient care is clearly evident.

The most frequent form of care organised by the Community Liaison nurse, when referring the patients to community services, were wound dressings (36,5%), basic nursing care and supervision (30,5%), and general follow-up (28.7%). Eighty-seven percent of all the patients were referred to the Day Hospitals Organisation, 75% to the Day Hospital District Nursing Service, and 12% to the Day Hospital Organisation clinics. The major after-care nursing load therefore devolves on the Day Hospitals Organisation. Considering the number of referrals to the Day Hospital District Nursing Service from Groote Schuur Hospital alone, it is clear that the establishment of twenty-five District Nurses is inadequate.

Only ten percent (76 cases) of the referrals were made to the Local Health Authority health visitors. This service appears to be underutilised, as the health visitor has a role to play in co-ordinating the health care of any chronically ill patient in her area. It is therefore essential that she be notified of such a patient's discharge from hospital. Only two percent (12 cases) of the referrals were made to Voluntary Organisations. The resources of these organisations are limited, and cannot meet the needs of pensioners or indigent patients discharged from Groote Schuur Hospital.

In the five month period from August to December, 808 patients, requiring varying degrees of home care, were referred to the community liaison nurse. Feedback from referral sources and families has been positive. However only a follow-up study could establish the long-term effectiveness of this service. Nevertheless, evidence presented in this study suggests that a community liaison nurse can make a substantial contribution towards the care of elderly and chronically ill patients. It is apparent that the community liaison nurse's expertise is fully extended in the Medical and Surgical wards of Groote Schuur Hospital. The complexity of cases varies considerably, but on average approximately one hour per patient is required to arrange aftercare facilities.

The activities of a community liaison nurse should be primarily to ensure continuity of care, by enlisting the aid of community health agencies. Her involvement in planning this care differs considerably between Medical Casualty, Out-patients and the wards at Groote Schuur Hospital. The patient's stay in Medical Casualty and

Out-patients Department is short, whereas bed occupancy in the wards is longer. A degree of urgency is attendant on the patients referred from short-term units, and requires her active and immediate interraction. In the ward situation however, she functions in an advisory consultative capacity to the ward sister, assisting her to adhere to the principles underlying effective aftercare planning.

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PART FOUR

CHAPTER 10

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

When an individual, on discharge from hospital, becomes disabled in his capacity to look after his own daily needs, he becomes dependent upon others to supply help. When there is no competent relative or friend at hand, the adverse consequences of dependence may range from trivial discomfort to physical and emotional deterioration. To obtain appropriate assistance in such circumstances is a problem for any disabled patient. An adequate solution of the problem requires practical planning. It cannot always be achieved without the intervention of some health service, local authority or voluntary agency.

Throughout the study, emphasis has been placed on the provision of extended care facilities to geriatric patients. However, the majority of clients over the age of 60 years function adequately in the community without assistance from any health or welfare service. The problem, stated realistically is; how best can extended care facilities be provided for vulnerable patients? Age is merely one of the factors which may make an individual susceptible to becoming chronically ill and disabled.

Health care professionals need to become aware of the group of patients who can be regarded as vulnerable in

that they need extended care facilities on discharge from hospital. Vulnerable patients' needs, as regards aftercare, tend to be:-

* The aged
* Chronically ill patients
* Patients who live alone or without social support
* Patients whose illness leads to a temporary or permanent disability
* Patients who are hospitalised for prolonged periods

There is a need to teach students of medicine, nursing, physiotherapy and occupational therapy to be perceptive in identifying vulnerable patients. Vulnerable patients must be identified when they have contact with the Health Care System, either as an in-patient, an out-patient or in the community.

It is frequently the nurse who has the first contact with a client who is likely to need extended care facilities in the community. If nurses are introduced to a problem orientated approach as regards patient care, they will become expert at making a preliminary assessment of the functional ability and social circumstances of their patients. This will lead to great proficiency in anticipating problems regarding the provision of continuity of care in the community. Early identification of problems will lead to the more appropriate utilisation of the specialised skills of the paramedical staff members such as the social worker, the physiotherapist, the occupational therapist and voluntary organisations.

The Community Liaison nurse has proved to be an invaluable member of the health team of a large, acute, specialist

hospital. The activities of a Community Liaison nurse is primarily to ensure the continuity of care of patients being discharged, by enlisting the aid of community health agencies. Her involvement in planning this care differs considerably between Medical Casualty and the Out-patients Department, and the wards at Groote Schuur Hospital. The patient's stay in Medical Casualty and the Out-patients Department is short, and the degree of urgency accompanying the referrals requires the Community Liaison nurse to take active and immediate intervention. In the ward situation, the Community Liaison nurse functions in an advisory consultative capacity to the ward sister, assisting her to adhere to the principles underlying effective aftercare planning.

The need to extend the Department of Community Liaison is evident. The establishment of another post of Community Liaison nurse would allow one staff member to concentrate on the problems associated with the short-term care patients admitted to Medical Casualty and the Out-patients Department. This would free the existing Community Liaison nurse to concentrate her efforts on ensuring better aftercare planning for patients in the general wards of Groote Schuur Hospital.

The Community Liaison nurse has a definite role to play in the inservice training of hospital staff in assisting them to:-

* Identify vulnerable patients
* Assess patients' aftercare needs
* Utilise the appropriate community services effectively

The development of the Department of Community Liaison at Groote Schuur Hospital will lead to better use to be made of both hospital and domiciliary resources.

Technological and medical advances have inevitably led to increasing specialisation in many aspects of nursing care. Nurse specialists in the fields of oncology, stoma care, intensive care and psychiatry has improved the quality of care given to patients. These nurse specialists are an invaluable resource in nursing care planning, and should be used freely for consultation by the general nursing staff of both the hospital and the community. They have a considerable contribution to make in planning individualised and continuing care for patients who are chronically ill and disabled.

The need for increased effort in planning rehabilitative health services in South Africa is evident. It is strange that a country so advanced in acute care should be retarded in providing facilities for rehabilitation. This lack of planning in tertiary health care is leading to an increased pressure on the acute hospital facilities.

Continuity of care is an aim integral to nursing practice. It may be achieved by assessing the need of a vulnerable group of patients have for extended care facilities, and by assisting them and their families to overcome the difficulties in obtaining this assistance. The need to conserve the acute hospital resources results in an early discharge of patients. This results in a rising incidence of personal dependence amongst the discharged patients. This level of disability could reverse or delay recovery, and may lead to the readmission of the

patient to the acute hospital. To minimise this occurrence, it is essential that an active development of a policy leading to the promotion of adequate after-care is established. Such developments could establish a more systematic preparation for people leaving hospital.

RECOMMENDATIONS

The Discharge Procedure

The discharge of a patient from hospital is a critical point in the continuity of care of that patient. For this reason attemps must be made to:-

1. Give adequate notice of discharge dates to enable patients and their families to make appropriate domestic arrangements in advance.

2. Give written instructions to the patient on activity, diet, prostheses, effect of drugs and treatment. (Appendix 3)

3. To organised that discharge communications to community services be completed and sent immediately when patients leave hospital.

4. Plan programmes of aftercare well in advance of patient's discharge date, and organised in conjunction with the patient's general practitioner and staff of community services, to provide an unbroken service of nursing and personal care. Those continuing treatment as out-patients to be included in similar planned programmes. (Appendix 2)

Nursing Education

Cognizance must be taken of the importance a programme of continuing care would have for nursing education. There

is a need to dismantle stereotyped, ritualised nursing care, and substitute specific nursing activities tailored to meet the particular requirements of an individual patient. Nursing education should provoke a critical, evaluative attitutude. Training, which tends to be the situation in nursing education at present, tends to produce conformists rather than innovators.

1. Student nurses should be introduced during their clinical training to a problem orientated approach to nursing care planning (the Nursing Process). The emphasis on problem solving will encourage nurses to develop a more objective and logical approach to their work. A problem orientated approach to nursing care has the following advantages:-

   (a) Nursing care becomes goal orientated. Setting goals ensures that nurses and patients know what they are trying to achieve, and allows the care to be evaluated in terms of whether or not the goals have been met.

   (b) It creates further possibilities for multidisciplinary approaches to care by its easy accessibility to doctors, physiotherapists and other members of the health care team.

   (c) It encourages student nurses to take a more active part in planning patient care under guidance from senior members of staff. This involvement will make nursing more stimulating and challenging to learners.

(d) It encourages patients to take part in planning their care by enabling them to know the goals towards which they can aspire. (2, p82)

Medical and Community Services

Co-ordination and collaboration can be achieved even in a divided administration, provided health care workers are prepared to communicate.

1. In the Cape Peninsula, there is an increasing need for an Assessment Unit, affiliated to a unit with facilities for rehabilitation and the care of chronically ill patients. Initially, such an Assessment Unit may consist of as few as ten beds, but have the flexibility to enlarge if the need arose. A physician, specialised in Geriatrics, should lead the health team of such an Assessment Unit. Referrals to an Assessment Unit should be accepted from:-

   * The acute hospitals
   * The Day Hospitals Organisation
   * General Practitioners in the community

   The target population of such an Assessment Unit would be any patient who was chronically ill or disabled and in need of extended care facilities in the community. Admission to the Assessment Unit should be planned on a short-term basis.

2. Affiliated to the Assessment Unit should be a Rehabilitation Unit with a small in-patient unit,

and a Day Hospital. This would be a relatively inexpensive facility to plan, as the Day Hospital could consist of any large hall converted to deal with rehabilitation. A transport system would be needed to ensure that patients who were not able to get to the Rehabilitation Day Hospital on their own volition, could still do so. Appropriate times of attendance at a Rehabilitation Day Hospital would be from 9.00 a.m. - 3.30 p.m. A disabled patient frequently cannot cope with being prepared for hospital transport at 6.30 a.m. or 7.00 a.m., for an 8.00 a.m. appointment.

3. The ideal of a Rehabilitation Unit is that the key members of the health team involved in rehabilitation, i.e. the Occupational Therapist and the Physiotherapist, function together in an integrated and co-ordinated partnership.

4. It must be recognised that any health professional who wishes to make a relevant contribution to rehabilitation, must do so in the patient's own home environment. It is therefore essential that nurses, physiotherapists and occupational therapists become aware of the need to make the initial assessment, and evaluate the appropriateness of their rehabilitation planning, in the patient's home environment. This need to assess patients who require extended care facilities in their own home environment is particularly relevant in a country such as South Africa, where there is great diversity between the privileged and underprivileged members of society. Inappropriate health education,

given in ignorance of the patient's social environment, merely frustrates the patient and his family, and results in a loss of morale. The home assessment should be made by the member of the health team who is making the most vital contribution to the rehabilitation of the vulnerable patient, whether it be the nurse, social worker, physiotherapist or occupational therapist.

5. If a constructive attempt is going to be made to lessen the load which the chronically ill, disabled patients are making on acute hospital facilities, there is an urgent need to extend the domiciliary service of the Day Hospitals Organisation. The Day Hospitals Organisation, particularly the District Nurses, are taking 87% of the burden of providing extended care facilities for patients discharged from Groote Schuur Hospital. The District Nursing establishment of the Day Hospitals Organisation consists of twenty-five registered nurses. Although these nurses are dedicated, innovative health professionals, they are unable to give the patients referred to them, comprehensive care, due to their excessive workload. This results in a decrease in job satisfaction and morale. It is recommended that the establishment of District Nurses be increased, and that Nursing Assistants be appointed to perform some of the essential basic nursing care functions such as bathing, dressing, etc., which are vital to many of the patients who are chronically ill in the

community. The provision of domiciliary care is a relatively inexpensive means of providing health care. To admit such a patient into institutionalised care, because of the lack of domiciliary facilities, is inappropriate and uneconomical.

6. The need to extend rehabilitation facilities into the community could be resolved by the creation of community occupational therapy posts at the Day Hospitals. Physiotherapists are already employed by the Day Hospitals Organisation. These members of the health team would be instrumental in instructing Nursing Assistants and family members how to facilitate the rehabilitation of a disabled patient in his own home, once an initial assessment of the patient's situation has been achieved.

7. Ultimately, all domiciliary health services should function under one co-ordinating body. The artificial division between preventive and promotive care, and curative care is not practical. The diversification of health care professionals performing similar functions in the community cannot be cost-effective. The need for the co-ordination of the numerous community services which exist for patients requiring extended care facilities in the community is evident.

One way of dealing with this problem would be to establish a Co-ordinating Committee consisting of

representatives of the Voluntary Organisations, Health Care professionals, representatives of Local Authority, Provincial Administration and the Department of Health and Welfare, and concerned lay people. The main objective of such a Committee would be to investigate means of improving the co-ordination between community facilities and publicising the functions of these facilities to members of the community who have need of them. Ultimately, the Co-ordinating Committee could look into the possibility of centralising all facilities from one source, ideally the Assessment Unit.

Research

This nursing study provides some information on the needs of patients recently discharged from hospital. Further research to discover the needs of the chronically ill and disabled people in the community is urgently required. Areas of concern are:-

1. Research into the gaps iin service which make vulnerable patients, or their families, resort to using institutional care prematurely. From contact with clients, it appears that by providing solutions to relatively minor problems might encourage the chronically ill, disabled client to continue to function effectively in the community. Areas to be investigated further should be:-

(a) The provision of Day Care Centres at existing Old Age Homes for the aged living in the community. The sharing of lounge, dining-room and recreational facilities between the residents of Old Age Homes and Day Care clients has proved most successful in other parts of the world. The existence of this facility would alleviate the consistent responsibility of the family caring for an aged person. This is particularly relevant in a society where both members of the household are employed.

(b) Many chronically ill or aged people who live alone are anxious about their inability to contact help should an emergency arise. This is an area which could be investigated, as providing such clients with an alarm system could allow them to continue living independently in the community.

(c) Many families who care for an incontinent aged parent cannot cope with the excessive laundry. The establishment of a laundry service, run on similar lines to existing Nappy Services, may assist to alleviate this problem.

(d) The Home Help Service has proved to be the foundation of the care of disabled clients living in the community in other parts of the world. The possibility of increasing

this service, which is already being provided by C.P.W.O.A., needs to be investigated.

2. Research into the provision of specialised nursing care for patients suffering from cerebrovascular accidents needs to be undertaken. It is evident that these patients are being inadquately catered for by the health facilities in the Cape Peninsula.

Care of Terminally ill Patients

1. A Voluntary Organisation, St Luke's Hospital, is investigating the possibility of establishing a Hospice for terminally ill patients in the Cape Peninsula. It is planned that the Hospice would have in-patient facilities for the care of dying patients who are unable to cope at home. Affiliated to the Hospice would be a comprehensive home nursing service to assist families caring for terminally ill patients in their own homes.

The Hospice would provide a centre for research and the training of health professionals into the special needs of the terminally ill patient. It would also provide an invaluable resource of specialist knowledge to the people in the community doing the grassroot care. The need for this type of resource became evident in the survey on patients discharged from hospital. It is for these reasons that the St Luke's Hospital Organisation should be supported in its task in supplying a vital community need.

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APPENDIX 1

DEPARTMENT OF NURSING - UNIVERSITY OF CAPE TOWN

CONTINUITY OF NURSING CARE QUESTIONNAIRE

1	2	4	7
116	117	118	119

Surname

Forename

Address

Patient's No.

Sex

Age

Employment Status

Telephone No.

Area Code No.

Questionnaire No.

I am _____, a registered nurse. The Department of Nursing at the University of Cape Town are doing a survey to find out more about how people manage at home when they come out of hospital.

Would you help us by answering a few questions about yourself? I will write down what you say, but nothing you tell me will be passed on to anyone else. We are interested in getting the facts from as many people as possible, but we will undertake to keep the information confidential.

1	2
1	2

1) When did you come home from hospital?

1	2	4	7
3	4	5	6

2) How long were you in hospital?

48 hours or less
3-6 days
1 week, but less than 2
2 weeks, but less than 4
4 weeks, but less than 6
6 weeks, but less than 12
12 weeks or more

(I would like to ask about what happened just before you left hospital)

1	2	4	7
7	8	9	10

3) While you were in hospital, when were you told your definite discharge date?

Same day as discharge
One day before discharge
Two days before discharge
Three or more days before discharge
Not told
Not sure
Other (specify)

1	2	4	7
11	12	13	14

4) Who first told you this date?

Doctor
Sister
Nurse
Social Worker
Relative
Friend
Other (specify)
Not sure

2/...

2
16

5) Were your relatives/friends told your date of discharge?

Yes
No
Don't know

6) If yes, who told them?

4 7
19 20

Self
Doctor
Sister
Nurse
Social Worker
Other (specify)
Don't know
Not applicable

7) When were they told?

4 7
23 24

Day of discharge
One day before discharge
2 days before discharge
3 days before discharge
Other (specify)
Don't know
Not applicable

8) What did you think at the time about the date of your leaving hospital? Did you feel it was :-

4
6 27

Too soon
About right
Could have been earlier
Other (specify)

9) Now that you are home, what do you feel about your discharge date? Do you feel it was :-

4
9 30

Too soon
About right
Could have been earlier
Other (specify)

10) How did you get home from hospital?

4
2 33

Ambulance
Relative/friend's transport
Public transport
Taxi
Other

11) Was this satisfactory?

2
35

Yes
No

If no, "why not"? .....

12) How many people are there in your household?

1 2 4
36 37 38

Self only
One other
2 others
3 others
4 others
5 or more other

13) When you first got back home, was there someone with you to help you settle?

1 2
39 40

Yes
No

14) Who cared for you when you first came home?

1 2 4
41 42 43

No one
Relative
Neighbour
Friend
District Nurse
Other (specify)

When you first came out of hospital could you manage with the following?

15) Getting in and out of bed on your own?

1 2
44 45

No difficulty
Yes, but with difficulty
Unable to do without help

16) Getting to or using the toilet/commode?

1 2
46 47

No difficulty
Yes, but with difficulty
Unable to do without help

17) Having a bath, shower or "all over wash"?

1 2
48 49

No difficulty
Yes, but with difficulty
Unable to do without help

18) Dressing yourself?

1 2
50 51

No difficulty
Yes, but with difficulty
Unable to do without help

19) Putting on shoes and socks/stockings?

1 2
52 53

No difficulty
Yes, but with difficulty
Unable to do without help

20) Feeding yourself?

1 2
54 55

No difficulty
Yes, but with difficulty
Unable to do without help

1 2
56 57

21) Women - Combing and brushing your hair?
Men - Shaving yourself?

No difficulty
Yes, but with difficulty
Unable to do without help

1 2
58 59

22) Did anyone at the hospital ask you about how you would manage when you got home?

Yes
No
Not sure

1 2 4
60 61 62

23) Who asked you?

Doctor
Sister
Nurse
Social Worker
Other (specify)
Not applicable

24) What did you tell them?
(Verbatim)

1 2
63 64

25) Do you wish you had told the hospital more about your home situation?

Yes
No
Not sure

1 2
65 66

26) Did you have any treatment to carry out at home and/or medicines or tablets to take when you got home?

Yes
No
Don't know

1 2 4 7
67 68 69 70

27) If answer to No. 26 was Yes, what treatment was ordered?

(1) Medicine/Tablets
(2) Injections
(3) Dressing
(4) Nose/ear/eye/drops/spray
(5) Medicine and injections
(6) Medicine and dressings
(7) Medicine and drops or inhalants
(8) Injections and dressing
(9) Injections and drops
(10) Not applicable

5/...

28) Who gave you instructions about this/these?

1	2	4	7
71	72	73	74

Ward Sister
Nurse
Doctor
Pharmacist
No one
Written instructions only
Not applicable

29) If Yes, how did you find these instructions?

1	2
75	76

Clear
Confusing
Not applicable

30) Do you, or did you, need help with the treatment?

1	2
77	78

Yes
No
Not applicable

31) If Yes, who gives/gave you this help?

1	2	4	7
79	80	81	82

No one
Private Nurse
Paid help
District Nurse
Member of household
Friend/Neighbour
Other (specify)
Not applicable

32) Is there anything about the treatment that worries you?

1	2
83	84

No
Yes

If Yes, what? .....

33) When you were discharged, were you given an appointment at a follow-up clinic/Day Hospital/Private Doctor?

1	2
85	86

Yes
No
Not sure

34) Did you/or do you intend keeping this appointment?

1	2
87	88

Yes
No
Not sure

If No, ask "why not"? .....

35) Since you came out of hospital, has anyone visited you apart from friends and relations?

1	2
89	90

Yes
No

36) If Yes, who visited you?

1	2	4
91	92	93

District Nurse
Health Visitor
Home help
Social Worker
Meals on Wheels
Other (specify)

37) If a nurse visited, ask "when did she call"?

and,

38) Who asked her to call?

1	2	4
94	95	96

Self
Relative
Friend
Family Doctor
Hospital
Other (specify)

39) What was the purpose of her visit?
(Verbatim)

40) Did the hospital Social Worker visit you when you were in hospital?

1	2
97	98

Yes
No
Not sure

41) If Yes, what did she speak to you about?

1	2	4
99	100	101

Pension/Finance
Housing
Personal
Other
Not applicable

42) Did you feel that the hospital personnel did all they could to help you to return to your normal routine at home?
(Prompt and clarify if necessary)

1	2
102	103

Yes
No
Not sure

43) Since you left hospital, how much have you got about?

1	2	4
104	105	106

Travelled on a bus
Walked about outside
Walked about inside the house
Walked about only in one room
Stayed in a chair
Stayed in bed

7/...

1	2	4
107	108	109

44) Is there anything you feel is necessary to make you more comfortable at home?

If Yes, specify .....

.....

.....

1	2	4
110	111	112

45) Do you think you would benefit from regular visiting from persons outside your family?

If Yes, from whom .....

and.

1	2	4
113	114	115

What sort of assistance do you think this person would be able to give you?

.....

.....

.....

o*o*o*o*o*o*o*o*o*o*o*o*o*o*o

JD/gkf 25.3.81

APPENDIX 2

DISCHARGE CHECKLIST

	Yes	No	Action
1. Patient's family/friends have been informed and prepared?			
2. Transport is available?			
3. All clothes and property have been given back to the patient?			
4. All medicine, dressings, etc. provided?			
5. Patient (or carer, or both) has been instructed and fully understands: * Taking of medicine * Treatment * Exercises * Prosthesis/appliance functioning			
6. Patient has been referred to appropriate community service? * District Nursing Service * Health Visitor * Day Hospital Organisation * Social worker * Home Help Service * Meals-on-Wheels * Voluntary service			
7. Follow-up appointment made?			
8. Patient has instruction list and understands contents?			

Signed:-

Designation:-

Date:-

REFERENCE:

1. Skeet, M., (1980) Discharge Procedures. Practical Guidelines for Nurses, Nursing Times Publication, London.

APPENDIX 3

INSTRUCTION SHEET FOR PATIENT ON DISCHARGE
(To be filled in where possible by ward sister and patient together)

Name:-

Address on discharge:-

Hospital No.:-

Consultant:-

Ward Sister:-

Date of Admission:-

Date of Discharge:-

Treatment received:-

Treatment to be continued:-

* Dressing
* Medicine
* Diet
* Exercises
* Therapy
* Other

Effects of treatment or medicine:-

Possible side effects:-

Amount of activity desirable:-

Services arranged for home:-

Date services expected to start:-

Other advice/instructions:-

You should attend the Out-patients Department on _____ at _____
If you are worried about the continuation of your treatment, telephone _____

Signed:-

Designation:-

Date:-

REFERENCE:

1. Skeet, M., (1980) Dishcarge Procedure. Practical Guidelines for Nurses, Nursing Times Publication, London.

QUESTIONNAIRE - THE RESPONSIBILITIES OF WARD SISTERS

AN INQUIRY INTO THE RESPONSIBILITIES OF WARD SISTERS IS BEING CONDUCTED AS PART OF A LARGER PROJECT CONCERNED WITH THE STUDY OF NURSING CARE IN HOSPITALS

The following list of items represents nursing duties which are assumed to be of some importance in the care of a hospitalized patient.

Please read through the statements from A to J and then rank them from 1 to 10 in order of the priority you personally would give them when arranging your own work. Rate 10 as the most important responsibility and 1 as the least important.

		1 - 10
A.	All charts and records are accurately kept and up-to-date	....
B.	Bed utilization is good e.g. Admissions are rarely held up because beds are "blocked" by patients.	....
C.	Patients' relatives and other visitors have reasonable opportunities to obtain information or discuss particular problems with the staff.	....
D.	The medical staff can rely on treatments and medication being given according to their instructions.	....
E.	The domestic work is well organized and the ward always looks bright and clean.	....
F.	Nursing equipment and drugs are always in good order.	....
G.	Emergencies are dealt with calmly and without undue disturbance of ward routine.	....
H.	When patients are discharged they are able to carry on at home and readjust with the least possible difficulty.	....
I.	Students and/or pupil nurses receive adequate teaching and supervision.	....
J.	All clerical work is efficiently and competently dealt with.	....

THERE IS NO CORRECT OR INCORRECT RATING OF THESE ITEMS AS EACH SISTER SHOULD REFLECT HER PERSONAL VIEWS IN RELATION TO HER CURRENT WORKING SITUATION; THE RESPONSE TO THIS QUESTIONNAIRE WILL REMAIN ANONYMOUS.

© J. Dick,
DEPARTMENT OF NURSING,
U.C.T.

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GROOTE SCHUUR HOSPITAL : COMMUNITY LIAISON REFERRAL

Could we kindly refer this patient to you.

NAME: D.O.B.: FOLDER NUMBER:

ADDRESS: TEL.NO.:

ADDRESS DISCHARGED TO IF DIFFERENT FROM ABOVE:

NEXT OF KIN:

ADDRESS: TEL.NO.:

PATIENT REFERRED BY:

DATE OF ADMISSION: ATTENDANCE: DISCHARGED: WARD:

CONSULTANT: NEXT OPD APPOINTMENT: TRANSPORT

DIAGNOSIS/SUMMARY OF TREATMENT:

TREATMENT REQUIRED AND COMMENCEMENT DATE:

DRUGS REGIME:

PATIENTS UNDERSTANDING OF ILLNESS:

RELATIVES UNDERSTANDING OF ILLNESS:

PROBLEM AREAS:

OTHER HOSPITAL SERVICES INVOLVED (PRIOR TO DISCHARGE) (please tick):

☐ Physiotherapy ☐ Speech Therapy ☐ Occupational Therapy

☐ Medical Social Worker ☐ Voluntary ☐ Other

COMMUNITY SERVICES INVOLVED (please tick):

☐ District Nurse ☐ Home Help ☐ Physiotherapy

☐ Health Visitor ☐ Meals on Wheels ☐ Occupational Therapy

☐ Social Worker ☐ Voluntary ☐ Speech Therapy

☐ Day Centre ☐ Other

ASSESSMENT OF PATIENTS ABILITY (please tick as appropriate)

EMOTIONAL	Well adjusted		Easily upset		Prone to depression		
MENTAL	Lucid		Confused at times		Disorientated		
SIGHT	Normal		Poor		Nil		
HEARING	Normal		Poor		Nil		
MOBILITY	Walks alone		Walks with aid		Chair		Bedfast
STAIRS	Manages alone		Manages with aid		Cannot manage		
TOILET	Manages alone		Manages with aid		Commode		Incontinent
PERSONAL CLOTHING	Manages alone		Manages with aid		Cannot manage		
DIET	Normal		Light		Fluid		Speciel

Thank you for your co-operation.

DATE: _____ SIGNED: _____ DESIGNATION: _____

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